State of Iowa

Iowa Medicaid Enterprise

Health Information Technology and EHR Incentive Payment Program

Provider Incentive Payment Program (PIPP) User Manual – Full Version

Version No. 1.1

Presented by:

Policy Studies, Inc.

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4/6/2012	*1.0*	*TStanfill*	*Draft*
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1. Preface

This Provider Incentive Program Payment (PIPP) portal user manual is intended to provide Eligible Professionals (EPs) and Eligible Hospitals (EHs) guidelines to successfully navigate the Iowa Medicaid Enterprise (IME) Electronic Health Record (EHR) Provider Incentive Payment Program user (PIPP) portal.

The IME EHR Incentive Payment Program is for Medicaid providers eligible for the Medicaid EHR incentive payments outlined in the American Recovery and Reinvestment Act (ARRA) of 2009. EPs and EHs will use this portal to attest to adoption, implementation or upgrading of a certified Electronic Health Record system and to attest to Meaningful Use.

IME is providing this material as a reference to providers. IME will make every reasonable effort to ensure this material is accurate and up-to-date; however it is ultimately the responsibility of the providers to ensure they are submitting the required information in order to receive EHR incentive payments.

Complete definitions and rules can be found in the ARRA, Title XIX of the Social Security Act, the HITECH Act and 42 CFR Parts 412, 413, 422 and 495 Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. This guide is not intended to be used in lieu of the Final Rule or any above mentioned Acts for guidelines in qualifying and obtaining EHR incentive payments. Please refer to the above mentioned Acts and the Final Rule for clarifications.

If at any time you have a question, please check our FAQs first. If you still need assistance, please contact the IME EHR Incentive Program staff by sending an email to imeincentives@dhs.state.ia.us. A member of the staff will respond to your inquiry.

2. External Users - EP and EH

ATTENTION: This application requires Silverlight. Silverlight is free and can be downloaded at http://www.silverlight.net/downloads. Please contact your IT staff if you need assistance.

Prior to gaining access to the IME PIPP portal, EHR registration must be completed at the CMS Registration and Attestation website. Once IME receives notice from CMS (in an overnight update file) indicating a provider has successfully registered for a Medicaid incentive payment from Iowa, PIPP sends an invitation to register with IME using IME PIPP portal. The invitation is sent to the email address used during CMS registration.

2.1 *Registration*

Upon receipt of the email invitation to register in IME PIPP portal, go to http://www.imeincentives.com to create an account.

2.1.1 Access Provider Web Registration

Click on the 'Provider Web Registration' link on the left side of the screen.

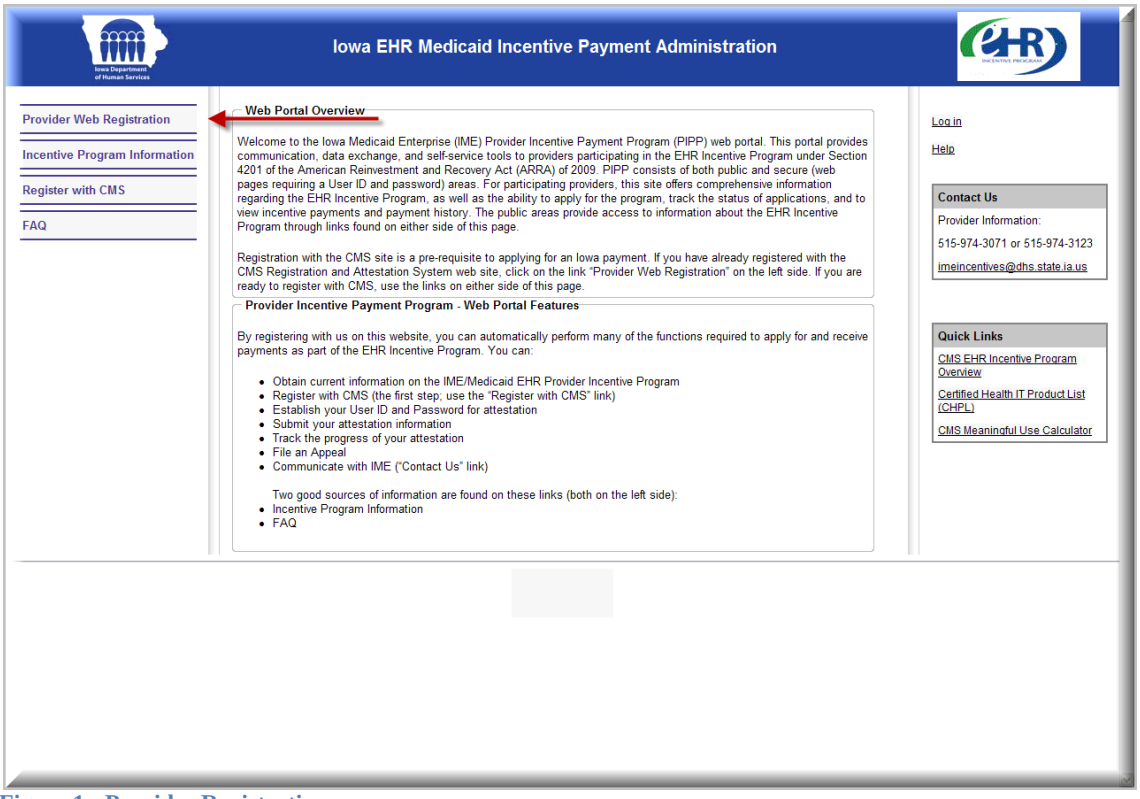
Iowa EHR Medicaid Incentive Payment Administration
Provider Web Registration
Incentive Program Information
Register with CMS
FAQ
Web Portal Overview
Welcome to the Iowa Medicaid Enterprise (IME) Provider Incentive Payment Program (PIPP) web portal. This portal provides communication, data exchange, and self-service tools to providers participating in the EHR Incentive Program under Section 4201 of the American Reinvestment and Recovery Act (ARRA) of 2009. PIPP consists of both public and secure (web pages requiring a User ID and password) areas. For participating providers, this site offers comprehensive information regarding the EHR Incentive Program, as well as the ability to apply for the program, track the status of applications, and to view incentive payments and payment history. The public areas provide access to information about the EHR Incentive Program through links found on either side of this page.
Registration with the CMS site is a pre-requisite to applying for an Iowa payment. If you have already registered with the CMS Registration and Attestation System web site, click on the link "Provider Web Registration" on the left side. If you are ready to register with CMS, use the links on either side of this page.
Provider Incentive Payment Program - Web Portal Features
By registering with us on this website, you can automatically perform many of the functions required to apply for and receive payments as part of the EHR Incentive Program. You can:
Obtain current information on the IME/Medicaid EHR Provider Incentive Program
Register with CMS (the first step; use the "Register with CMS" link)
Establish your User ID and Password for attestation
Submit your attestation information
Track the progress of your attestation
File an Appeal
Communicate with IME ("Contact Us" link)
Two good sources of information are found on these links (both on the left side):
Incentive Program Information
FAQ
Log in
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 1 - Provider Registration

2.1.2 **Locate Provider Profile**

Enter the required information to locate your provider profile. This information must match the individual or hospital data used to register with CMS R&A.

- CMS Registration Number
  - This is the number received after completing registration at the CMS Registration and Attestation web site. If you have forgotten or lost this number, please call the CMS Help Desk at 1-888-734-6433. IME does not have this number.
- NPI
  - This is the NPI you used to register with CMS. If you are an Eligible Professional, this is your individual NPI.
- Tax ID
  - This is the Tax ID you used to register with CMS. If you are an Eligible Professional, this is your individual Tax Identification Number (TIN) or your Social Security Number (SSN).

Click 'Find'.

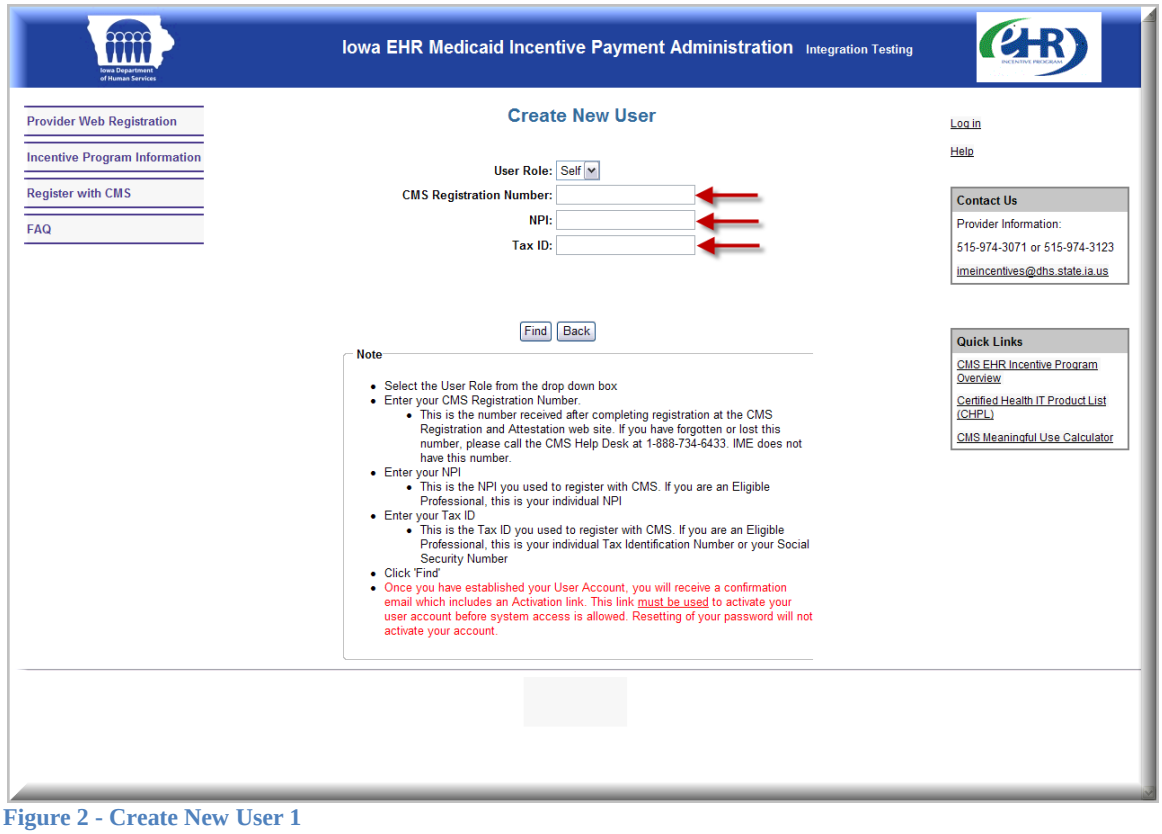
Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
Provider Web Registration
Incentive Program Information
Register with CMS
FAQ
Create New User
User Role: Self
CMS Registration Number:
NPI:
Tax ID:
Find
Back
Log in
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator
Note
Select the User Role from the drop down box
Enter your CMS Registration Number.
This is the number received after completing registration at the CMS Registration and Attestation web site. If you have forgotten or lost this number, please call the CMS Help Desk at 1-888-734-6433. IME does not have this number.
Enter your NPI
This is the NPI you used to register with CMS. If you are an Eligible Professional, this is your individual NPI
Enter your Tax ID
This is the Tax ID you used to register with CMS. If you are an Eligible Professional, this is your individual Tax Identification Number or your Social Security Number
Click 'Find'
Once you have established your User Account, you will receive a confirmation email which includes an Activation link. This link must be used to activate your user account before system access is allowed. Resetting of your password will not activate your account.

Figure 2 - Create New User 1

2.1.3 Create New User Name and Password

If you receive an error after entering your information, the system is unable match the data entered with any active registration data from CMS. Verify the data keyed in. If the data is correct according to your records and the system is still unable to match your registration data, contact CMS at 1-888-734-6433 or return to the CMS R&A website to check your eligibility status and registration data.

Once PIPP validates your provider data, the PIPP portal will prompt you to create a User Name and Password.

The following fields are pre-populated with the data received from CMS. You are responsible for verifying this data is accurate. If any of the pre-populated data is incorrect, you must return to the CMS R&A System website to make corrections. IME cannot make corrections to the following information.

- CMS Registration Number
- NPI
- Tax ID
- First Name
- Last Name
- Email Address

NOTE: *ALL email correspondence is sent to the address listed on this screen.*

You must enter data in the remaining fields to complete registration. All fields on this screen are required.

2.1.3.1 *Create New User Name*

The User Name must have the following properties:

- Must be between 6 and 10 characters long
- May contain a combination of alphanumeric characters
- Must NOT contain non-alphanumeric characters
- User Name is not case sensitive

2.1.3.2 *Create Password*

The Password must have the following properties:

- Must be between 7 and 10 characters long
- Must contain at least one non-alphanumeric character
- Must contain at least one upper case character

- Must contain at least one lower case character

2.1.3.3 *Answer Security Questions*

Security questions are used in the event the User Name and/or Password needs to be recovered or reset.

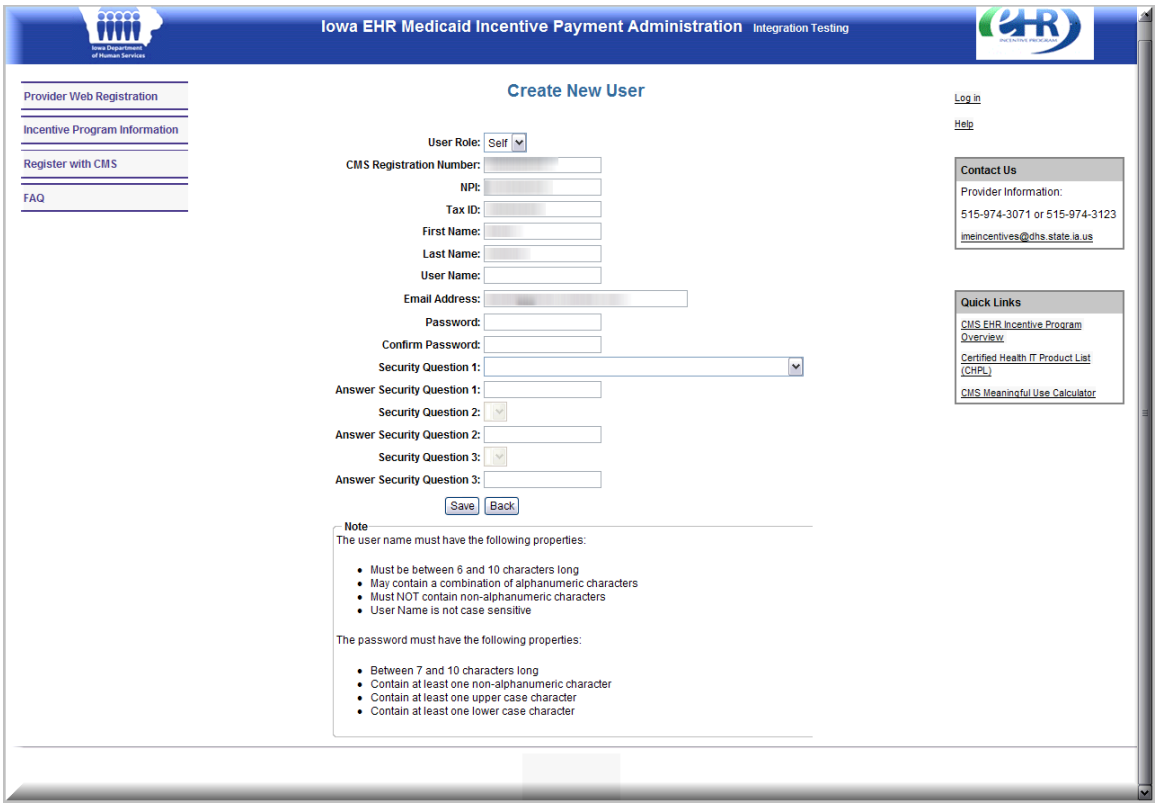

Figure 3 - Create New User 2

2.2 *Activate Log In User ID*

Once you create your account, PIPP sends an activation email to the email address registered with the CMS R&A system.

Click on the link provided to activate your account. You must click on the link to activate your account in order to be granted access to the PIPP portal.

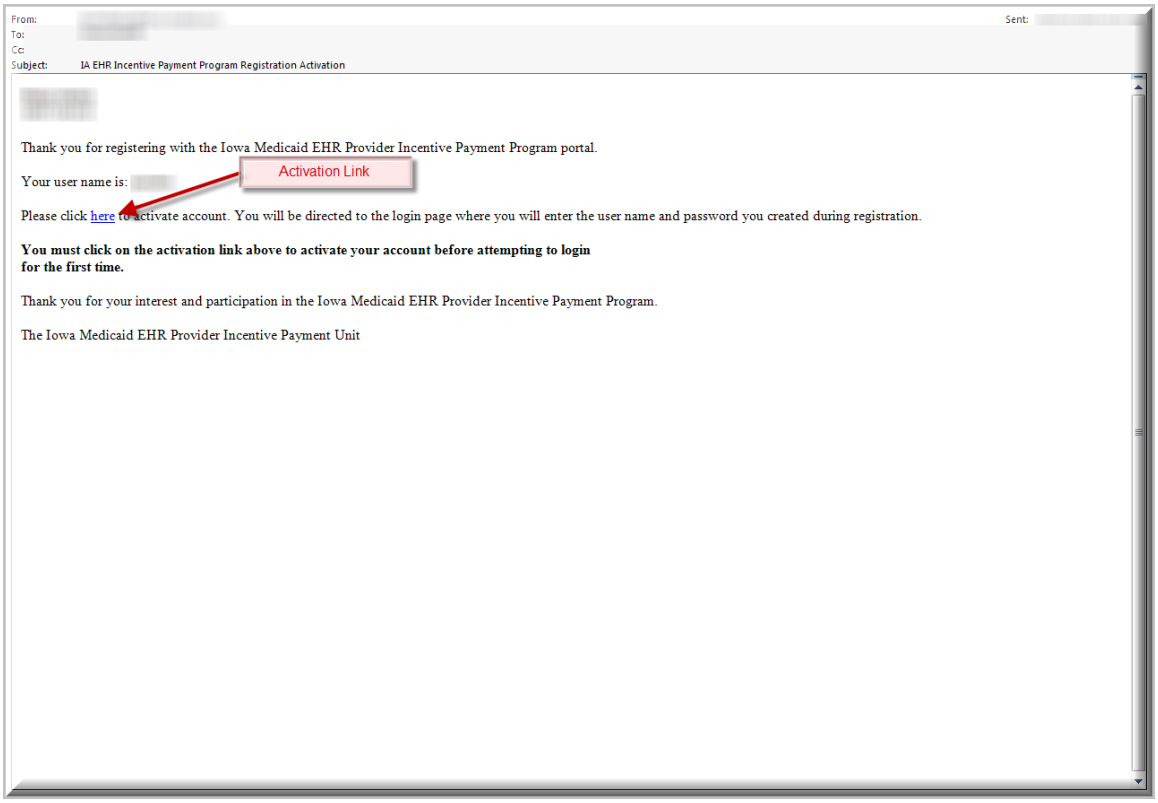
From:
Sent:
To:
Cc:
Subject: IA EHR Incentive Payment Program Registration Activation
Thank you for registering with the Iowa Medicaid EHR Provider Incentive Payment Program portal.
Your user name is:
Activation Link
Please click here to activate account. You will be directed to the login page where you will enter the user name and password you created during registration.
You must click on the activation link above to activate your account before attempting to login for the first time.
Thank you for your interest and participation in the Iowa Medicaid EHR Provider Incentive Payment Program.
The Iowa Medicaid EHR Provider Incentive Payment Unit

Figure 4 - Activation Email

2.3 *Log In*

When you click on the link provided in the activation email, you will be directed to the IME PIPP Portal Log In screen.

Enter the User Name and Password created during IME PIPP portal registration to begin your application for an IME EHR incentive payment.

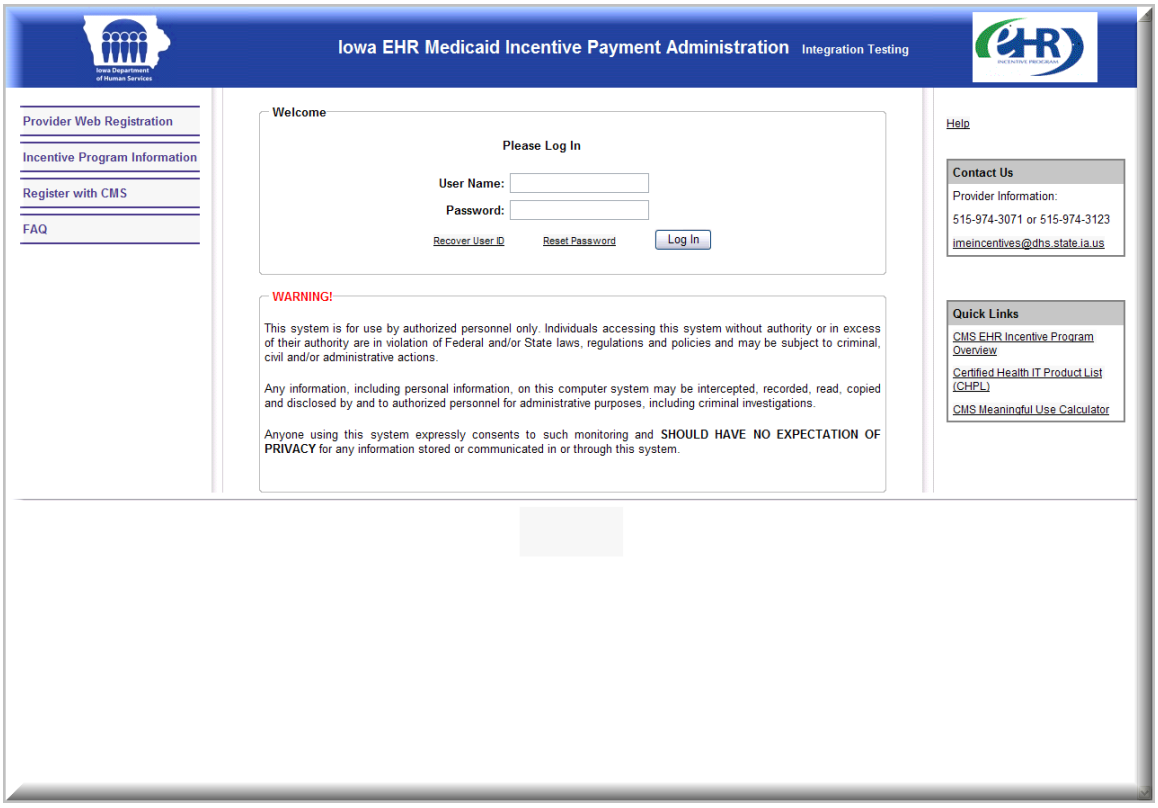
Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
Provider Web Registration
Incentive Program Information
Register with CMS
FAQ
Welcome
Please Log In
User Name:
Password:
Recover User ID
Reset Password
Log In
WARNING!
This system is for use by authorized personnel only. Individuals accessing this system without authority or in excess of their authority are in violation of Federal and/or State laws, regulations and policies and may be subject to criminal, civil and/or administrative actions.
Any information, including personal information, on this computer system may be intercepted, recorded, read, copied and disclosed by and to authorized personnel for administrative purposes, including criminal investigations.
Anyone using this system expressly consents to such monitoring and SHOULD HAVE NO EXPECTATION OF PRIVACY for any information stored or communicated in or through this system.
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 5 - Log in Screen

2.3.1 **Provider Dashboard**

The main provider screen (Provider Dashboard) displays any email communications sent to the email address registered with the CMS R&A system, as well as the status of your attestation, payment history (if applicable) and additional guidelines for completing your application.

The following table describes the possible statuses of your application:

Status	Description
CMS Received	Notification EHR registration has been received from CMS
Application Pending	Application process has begun, but is not yet submitted If your application is returned to you by IME for any reason, the status is reset to Application Pending. You will need to correct or include any requested information and re-confirm all question pages.
Application Review	Provider Application is complete – Submitted for Review
Application Review Secondary	Application is in the second phase of the review process
Application Review Supervisor	Application is in the third phase of the review process
Pending CMS Review	IME review complete – awaiting approval from CMS to release payment
Ready for Payment	Notification of CMS approval for payment received by IME
Payment Pending	Payment being processed by IME
Payment Complete	Payment issued by IME
Payment Rejected by CMS	Notification of CMS payment rejection received by IME
Application Denied	Application is denied by IME
Cancelled by CMS	Registration is INACTIVE at CMS – the State was notified by CMS that the provider registration has been inactivated. The provider will need to contact CMS.

Table 1 - Application Statuses

2.4 *Complete Application*

On the left side of the Provider Dashboard screen, click on the 'Apply for Incentive (Attest)' link.

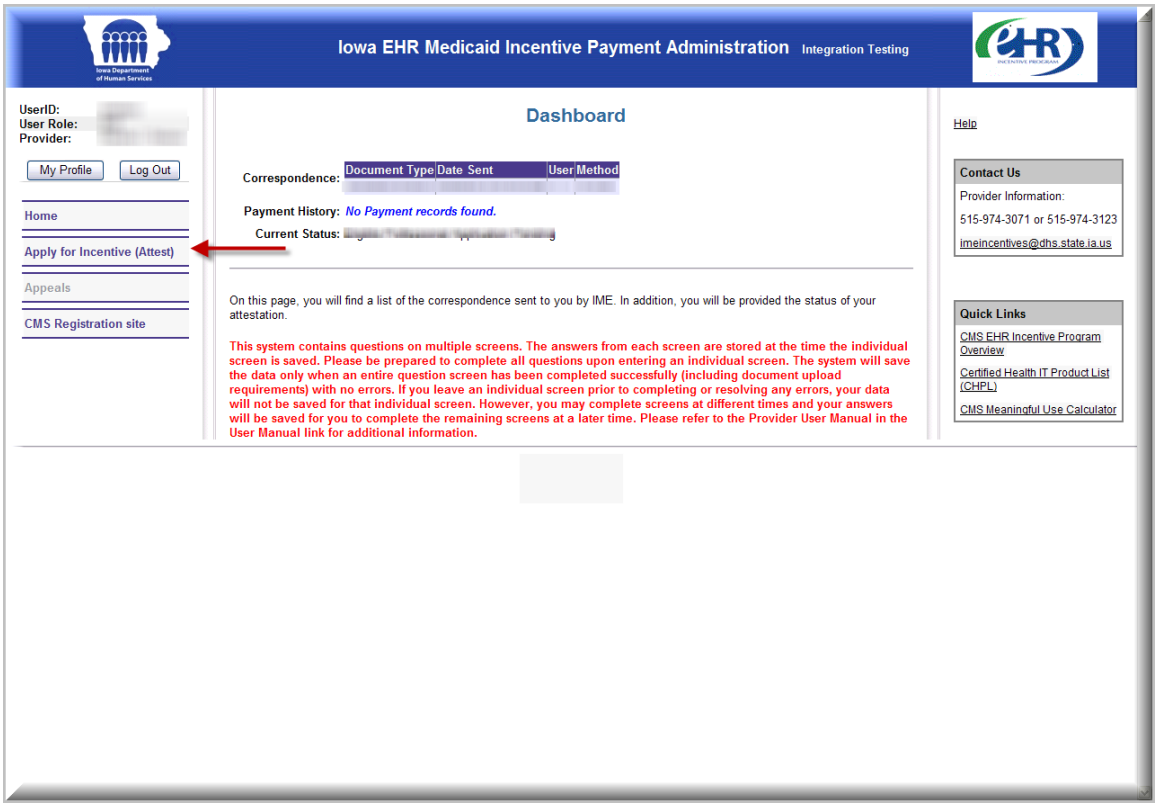
Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
Dashboard
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Correspondence:
Document Type
Date Sent
User Method
Payment History:
No Payment records found.
Current Status:
On this page, you will find a list of the correspondence sent to you by IME. In addition, you will be provided the status of your attestation.
This system contains questions on multiple screens. The answers from each screen are stored at the time the individual screen is saved. Please be prepared to complete all questions upon entering an individual screen. The system will save the data only when an entire question screen has been completed successfully (including document upload requirements) with no errors. If you leave an individual screen prior to completing or resolving any errors, your data will not be saved for that individual screen. However, you may complete screens at different times and your answers will be saved for you to complete the remaining screens at a later time. Please refer to the Provider User Manual in the User Manual link for additional information.
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 6 - Apply for Incentive (Attest)

2.4.1 **EP Provider Attestation Information (YEAR 1 – AIU)**

This section covers instructions for EPs attesting for the first time (Program Year 1). If you have already attested for Payment Year 1 please review this section as you will need to answer the same questions for Program Year 1 each year you apply for an EHR Incentive Payment from IME. Section 2.4.2 covers the additional Meaningful Use questions that are required for Program Years 2 through 6.

Clicking on 'Apply for Incentive (Attest)' link will display the Provider Attestation screen.

The 'Provider EHR Criteria' section displays the attestation question pages that must be completed. Begin your application by selecting one of the 'Attest' links. You must respond to all of the questions on each page. Once you have answered the questions on a page, click "OK", if no errors are received your data is saved and you will be returned to the Provider Attestation main page to select another question page. If errors are displayed, you must correct any errors before your data is saved. You have

the ability to change your answers on any page up until your application is submitted for review.

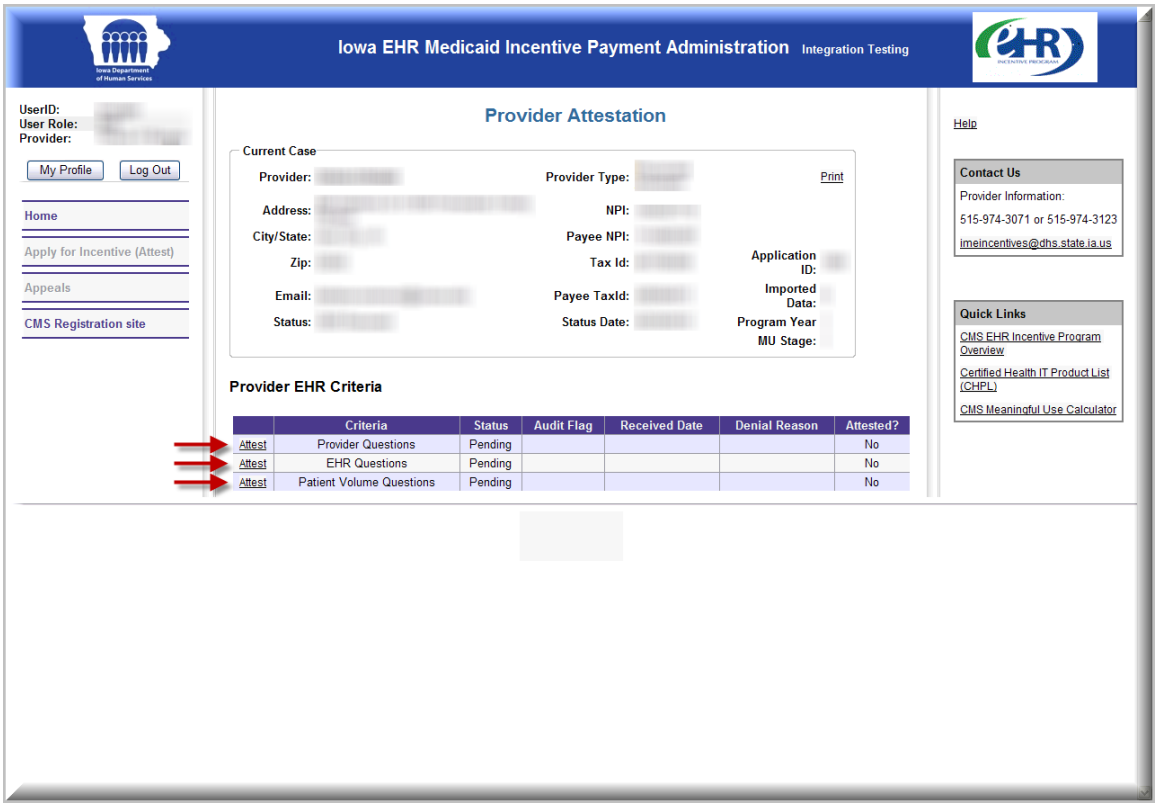

Figure 7 - EP Provider Attestation

Each page must be completed successfully to submit an application for an incentive payment.

Criteria:

- Provider Questions – General questions used to determine incentive payment eligibility
- EHR Questions – Questions specific to the certified EHR system/module(s) you use
- Patient Volume – Questions specific to the Medicaid patient volume requirement of the program

Status:

- Pending – Answers have not been confirmed or saved
- Attested – Answers have been confirmed or saved
- Pass – Question page has been approved in one or more of the IME review processes

- Fail – Question page has been denied in one or more of the IME review processes

Received Date – Date of the latest status change

Denial Reason – Return and denial reasons are displayed in this column

Attested? – "No" will change to "Yes" as you complete each page.

2.4.1.1 *Provider Questions*

NOTE: These questions are the same for all Payment Years.

- Are you currently enrolled as an Iowa Medicaid provider?
  - Yes
  - No - You will be required to agree to an additional set of terms and conditions prior to your application being reviewed
- My professional license number is:
  - Enter your state-issued professional license number
- Do you have any sanctions pending against you?
  - Yes – A text box is displayed for you to enter a brief description of the sanction(s). The description is limited to 100 characters. Please upload any necessary supporting documentation or comments.
  - No
- What is the NPI of the organization for which you bill?
  - Please enter your Billing NPI
- Hospital-based EPs are not eligible for the incentive payment. Are you a hospital-based provider?
  - Yes – You cannot be hospital-based and qualify for an EHR incentive payment unless you are an EP that practices predominately in an FQHC or RHC. An EP is defined as being hospital-based, and therefore ineligible to receive EHR incentive payments under either Medicare or Medicaid, regardless of the type of service provided, if 90 percent or more of their services are identified as being furnished under place of service codes 21 (Inpatient Hospital) or 23 (Emergency Room, Hospital).
  - No
- Are you a Pediatrician?
  - Yes – The patient volume threshold for pediatricians is 20%. Pediatricians that have at least 20% Medicaid patient volume but less than 30% will receive a reduced incentive payment. If a pediatrician reports patient volume over 30%, the pediatrician will receive the full incentive payment.
  - No
- Do you practice predominately in an FQHC/RHC?

- FQHC
- RHC
  - EPs that practice predominately in an FQHC or RHC are not subject to being excluded as Hospital-Based EPs and are able to use the Needy Individual population to meet their patient volume threshold of 30%. An EP "Practices predominately" at an FQHC or RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year occurs at an FQHC or RHC.
- No
- *Physician Assistants Only*
  - *PAs will be required to provide additional information to demonstrate the FQHC or RHC is 'so led' by a PA*
  - *How is your clinic 'so led' by a PA?*
    - *For FQHCs*
      - *PA is the Director of the Clinic*
      - *PA is the Primary Provider*
    - *For RHCs*
      - *PA is the Director of the Clinic*
      - *PA is the Owner of the Clinic*
      - *PA is the Primary Provider of the Clinic*

- Are you attesting at group or individual level?
  - Group
  - Individual
- *For Physician Assistants, Certified Nurse Midwives and Nurse Practitioners Only:* Are you currently seeing Medicaid patients billed through a supervising physician?
  - Yes – Supervising physicians NPI is required
  - No
- Do you practice in multiple locations?
  - Yes – Click on 'Add Address' to enter the addresses of all locations where you provide services. You are required to enter at least two addresses.
  - No
- Upload supporting documentation.
  - License Verification
  - Proof of PA Clinic
  - Proof of PA Director
  - Proof of PA Ownership
  - Proof of PA Primary
  - Sanctions Detail
  - Other

PA's are required to upload proof of their clinic being 'so led' by a PA.

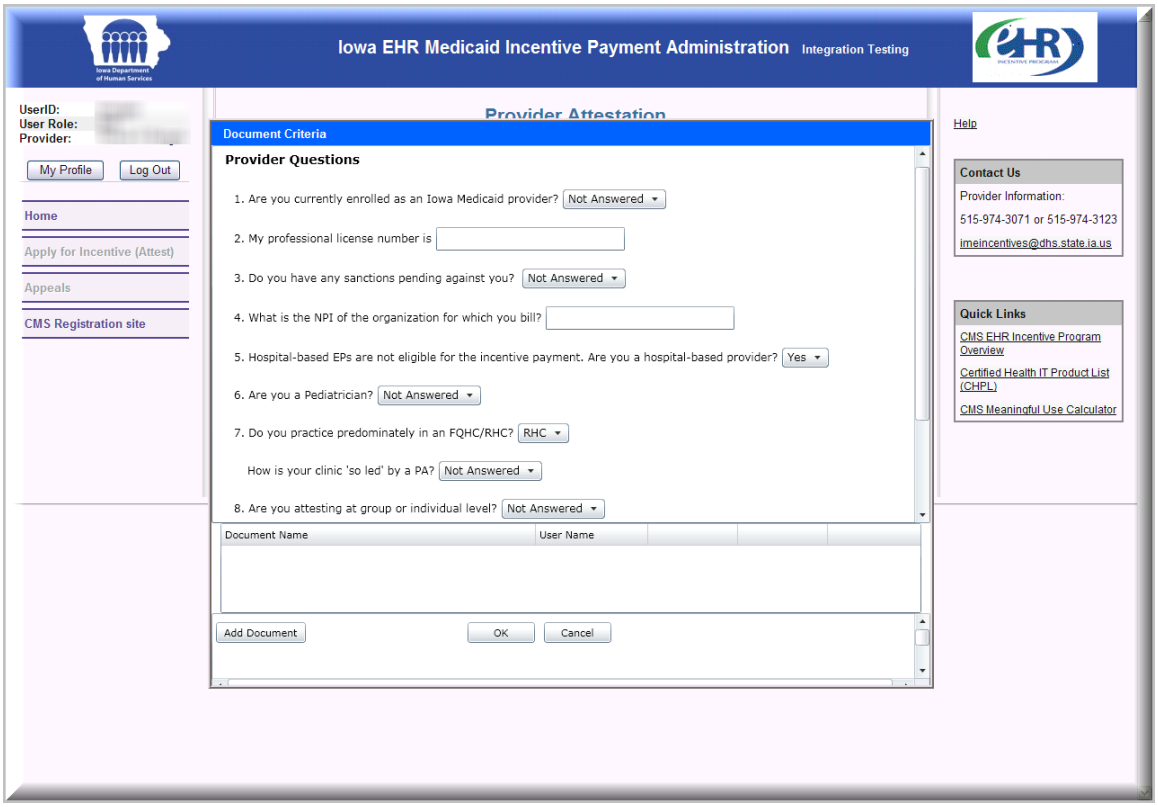
Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Provider Attestation
Document Criteria
Provider Questions
1. Are you currently enrolled as an Iowa Medicaid provider? Not Answered
2. My professional license number is
3. Do you have any sanctions pending against you? Not Answered
4. What is the NPI of the organization for which you bill?
5. Hospital-based EPs are not eligible for the incentive payment. Are you a hospital-based provider? Yes
6. Are you a Pediatrician? Not Answered
7. Do you practice predominately in an FQHC/RHC? RHC
How is your clinic 'so led' by a PA? Not Answered
8. Are you attesting at group or individual level? Not Answered
Document Name
User Name
Add Document
OK
Cancel
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
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Figure 8 - EP Provider Questions 1

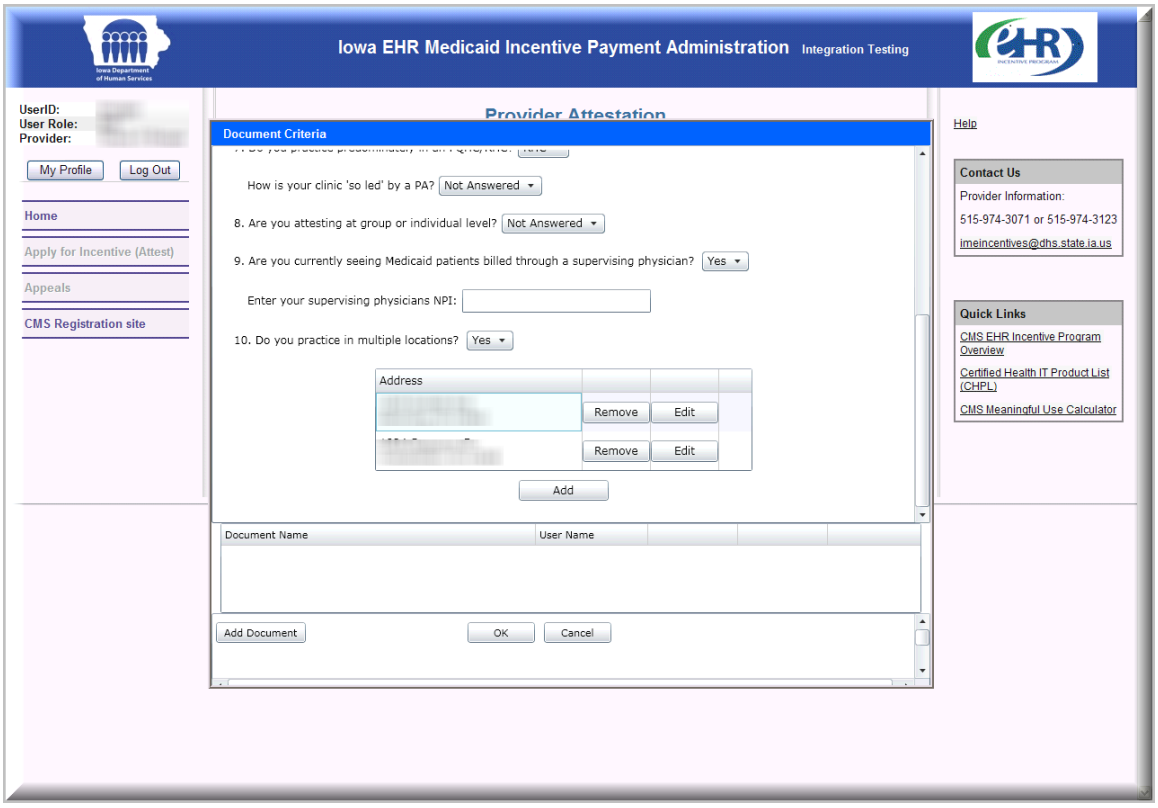


Figure 9 - EP Provider Questions 2

2.4.1.2 *EHR Questions*

- Have you adopted, implemented or upgraded to certified electronic health record (EHR) technology?
  - Yes
  - No – In order to attest, you must have adopted, implemented or upgraded to certified electronic health record technology.
- CMS EHR Certification number:
  - If you included your EHR Certification number in your CMS registration, this field is pre-populated with that number. Please verify this number is accurate and correct if needed. You can make the correction either at the CMS site or on the PIPP site.
  - If you did not include your EHR Certification number in your CMS registration you must enter this number here. A valid EHR Certification number is required on this page.
  - FOR MEANINGFUL USE YEARS:
    - The CMS EHR Certification number used in previous years will not be displayed; you will need to enter your EHR Certification number.
      - A valid EHR Certification number must be entered
      - If the EHR Certification number you enter does not match the EHR Certification number on record for previous years, you will be required to upload supporting documentation for the new EHR technology.
- Name, version, and description of Certified EHR System:
  - Enter the name, version and a brief description of your Certified EHR technology in the text box provided. The text box is limited to 100 characters. If more space is needed please attach a document with additional details.
- Upload supporting documentation
  - Invoice
  - Receipt
  - First Page and Signature Page of Contract
  - Other – Please specify

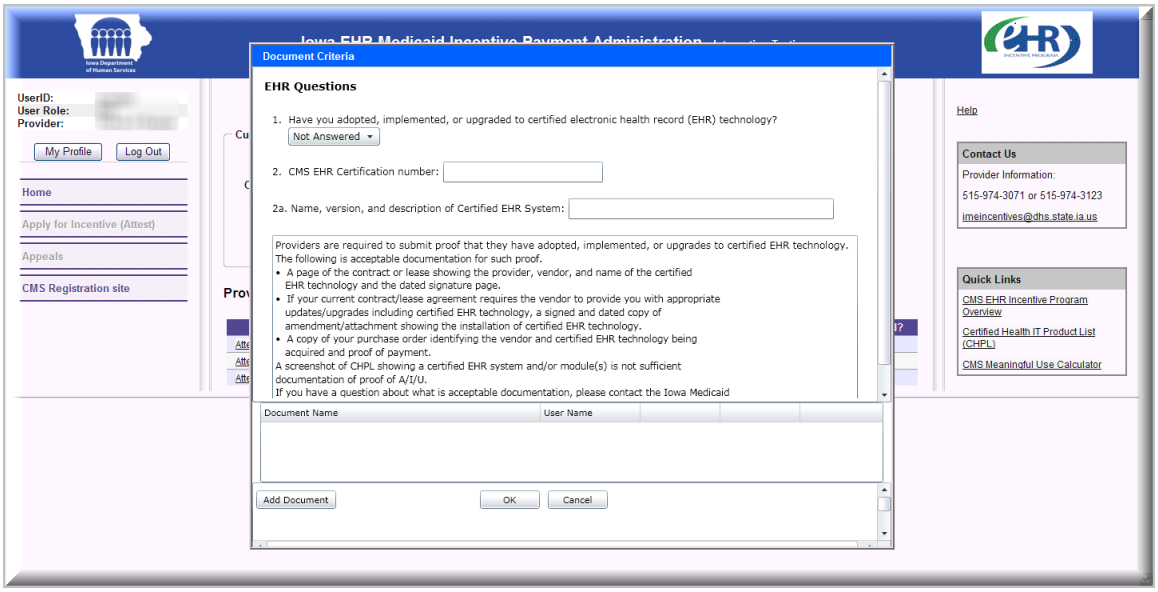
Documentation that proves you have Adopted, Implemented or Upgraded (AIU) your EHR system **is required** the first time you apply, or if you change your EHR technology in subsequent year applications. At least one supporting document must be uploaded.

Acceptable documentation for such proof:

- A page of the contract or lease showing the provider, vendor and name of the certified EHR technology and the dated signature page

- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment

A screenshot of CHPL showing a certified EHR system and/or modules is not sufficient documentation of proof of A/I/U.


Document Criteria
EHR Questions
1. Have you adopted, implemented, or upgraded to certified electronic health record (EHR) technology?
Not Answered
2. CMS EHR Certification number:
2a. Name, version, and description of Certified EHR System:
Providers are required to submit proof that they have adopted, implemented, or upgrades to certified EHR technology.
The following is acceptable documentation for such proof.
• A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
• If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
• A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.
A screenshot of CHPL showing a certified EHR system and/or module(s) is not sufficient documentation of proof of A/I/U.
If you have a question about what is acceptable documentation, please contact the Iowa Medicaid
Document Name
User Name
Add Document
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator
Figure 10 - EP EHR Questions

2.4.1.3 *Patient Volume Questions*

If you are applying during the 60-day grace period following the end of the payment year, you will be required to identify the payment year you are applying for.

- Select the beginning date for the 90-day period you are using to meet the patient volume requirement. For EPs this period must be in the preceding calendar year. The end date of the 90-day qualifying period is auto-calculated for you.
  - Begin Date – mm/dd/yyyy
  - End Date – mm/dd/yyyy (auto-calculated)
- What is the total number of patient encounters within the selected 90-day period? (i.e. your denominator)
  - Enter the TOTAL patient encounter count for the selected 90-day period.
- What is the total number of paid Medicaid encounters for the selected 90-day period? (i.e. your numerator)

  - Enter the paid Medicaid encounter count (or the Needy Individual count if applicable) for the 90-day period.
- Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:
  - This percentage is automatically calculated using the numerator and denominator entered above
- Are any of your Medicaid patients covered by another state's Medicaid program?
  - Yes – A table displays to enter additional data. Enter the state abbreviation and the encounter count for that state. If you have your Medicaid Provider ID for that state please enter it here.
    - To ensure accurate multi-state reporting Iowa Medicaid encounters must also be reported in this table. IA is the default for your first entry.
  - No
- Does your 30% Patient Volume encounters include Needy Individuals?
  - This question displays only if you answered that you practice predominately in an FQHC or RHC on the Provider Questions page
  - Yes – Enter the following counts:
    - IME Medicaid
    - hawk-i (CHIP / Title XXI)
    - Uncompensated
    - No Cost or Reduced Cost
  - No
- What is the auditable data source you are using to calculate patient volume?
  - EHR system
  - Billing system
  - Appointment Book
  - Other – provide a brief description of the 'other' source
- Are you including inpatient encounters in your patient volume?
  - Yes
  - No
- Are you including encounters covered by Magellan in your numerator?
  - Yes – The count of Magellan encounters is required
  - No
- Are you including patients for whom you did not have encounter in the 90-day period from your MediPASS panel (but for whom you did see in the previous 12 months) in your numerator?
  - Yes – The count of MediPASS patients is required
  - No
- Upload supporting documentation
  - Proof of Patient Volume (required)
  - Other – Please specify

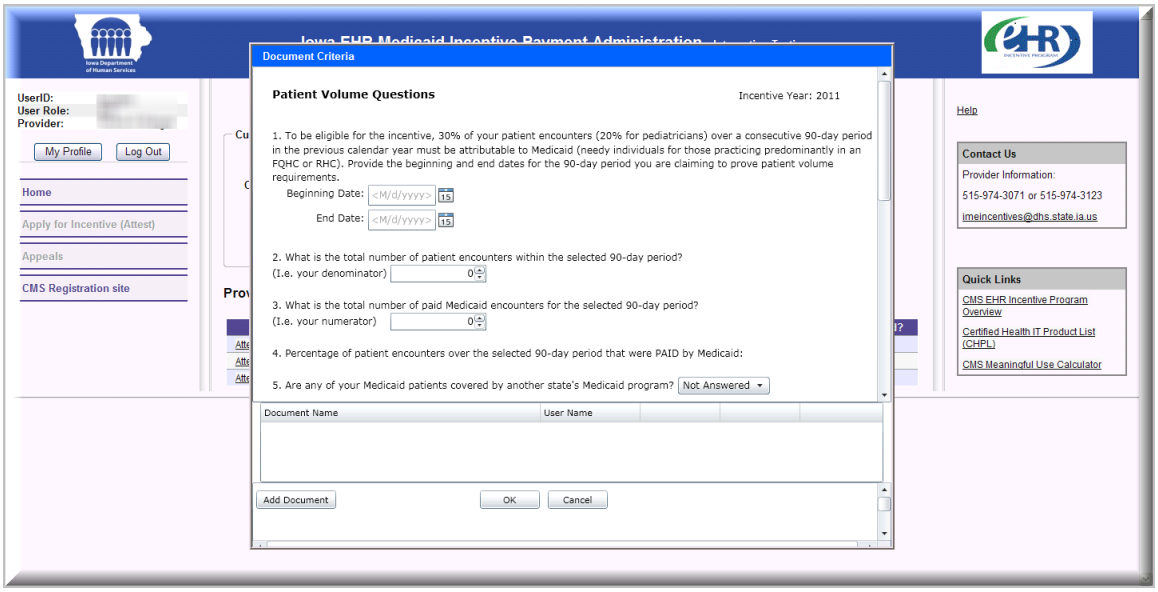

Document Criteria
Patient Volume Questions
Incentive Year: 2011
1. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). Provide the beginning and end dates for the 90-day period you are claiming to prove patient volume requirements.
Beginning Date:
End Date:
2. What is the total number of patient encounters within the selected 90-day period? (I.e. your denominator)
3. What is the total number of paid Medicaid encounters for the selected 90-day period? (I.e. your numerator)
4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:
5. Are any of your Medicaid patients covered by another state's Medicaid program? Not Answered
Document Name
User Name
Add Document
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 11 - EP Patient Volume 1

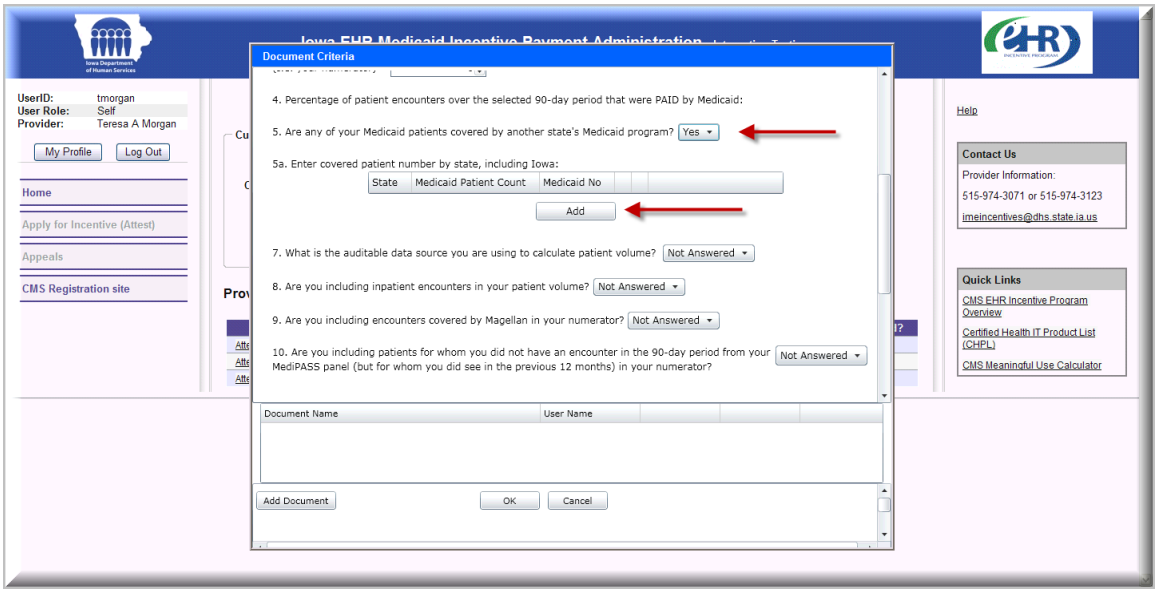

Document Criteria
4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:
5. Are any of your Medicaid patients covered by another state's Medicaid program? Yes
5a. Enter covered patient number by state, including Iowa:
State
Medicaid Patient Count
Medicaid No
Add
7. What is the auditable data source you are using to calculate patient volume? Not Answered
8. Are you including inpatient encounters in your patient volume? Not Answered
9. Are you including encounters covered by Magellan in your numerator? Not Answered
10. Are you including patients for whom you did not have an encounter in the 90-day period from your MediPASS panel (but for whom you did see in the previous 12 months) in your numerator? Not Answered
Document Name
User Name
Add Document
OK
Cancel
UserID: tmorgan
User Role: Self
Provider: Teresa A Morgan
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 12 - EP Patient Volume 2 - Other State Coverage

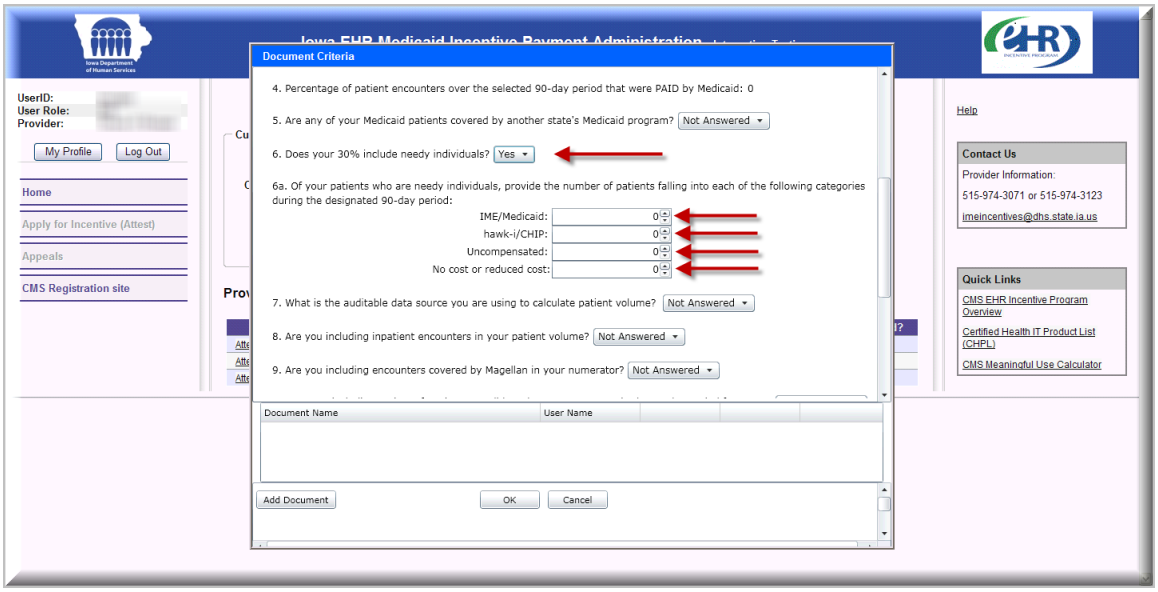

Document Criteria
4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid: 0
5. Are any of your Medicaid patients covered by another state's Medicaid program? Not Answered
6. Does your 30% include needy individuals? Yes
6a. Of your patients who are needy individuals, provide the number of patients falling into each of the following categories during the designated 90-day period:
IME/Medicaid:
hawk-i/CHIP:
Uncompensated:
No cost or reduced cost:
7. What is the auditable data source you are using to calculate patient volume? Not Answered
8. Are you including inpatient encounters in your patient volume? Not Answered
9. Are you including encounters covered by Magellan in your numerator? Not Answered
Document Name
User Name
Add Document
OK
Cancel

Figure 13 - EP Patient Volume 3 - Needy Individuals

2.4.2 **EP Provider Attestation Information (Meaningful Use Years)**

When attesting to Meaningful Use in Payment Years 2 through 6 you must complete the Meaningful Use Core, Menu and Clinical Quality Measure (CQM) pages in addition to the Provider Questions, EHR Questions and Patient Volume Question pages prior to submitting your attestation for review.

To access the Meaningful Use Core Set Questions, click on the 'Attest' link next to the Criteria named 'Meaningful Use Core Set Questions'.

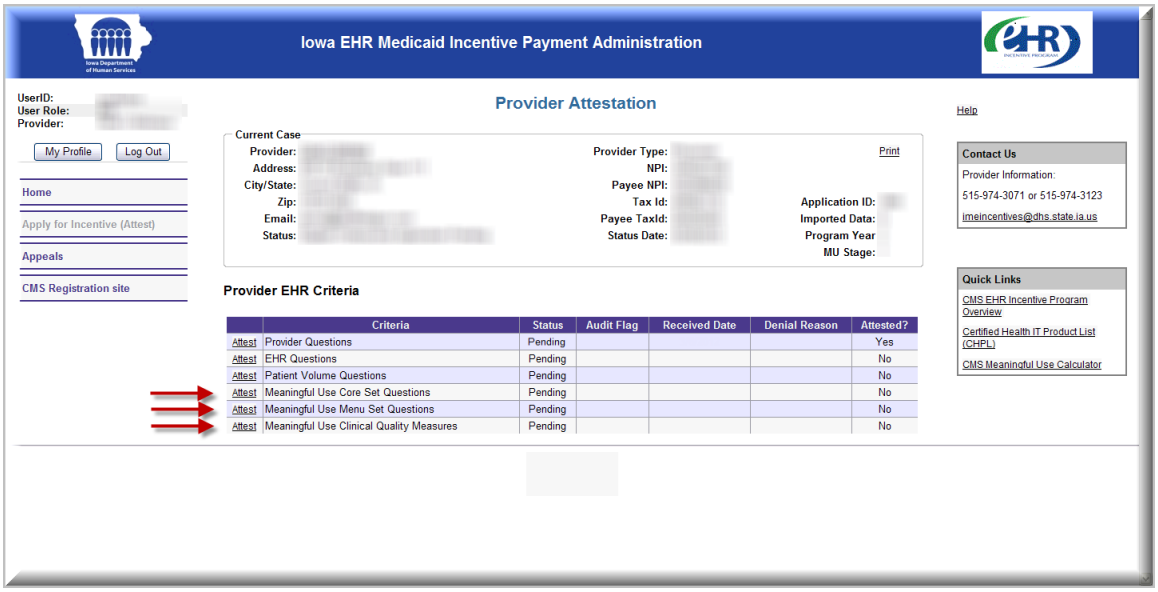


Figure 14 - Meaningful Use Attestation Pages

2.4.2.1 *Reporting Period*

Payment Year 2

If this is your first year attesting to Meaningful Use: Your reporting period is "any continuous 90-day period within the calendar year." per 42 CFR § 495.4 (1)(ii)(B).

Enter your selected Reporting Period in the first row of the Meaningful Use Core Set Questions page:

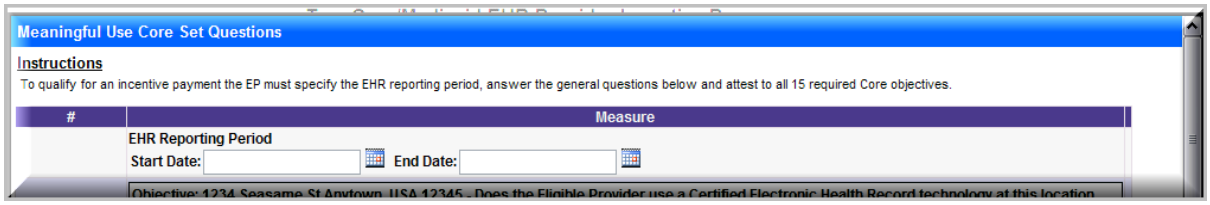

Meaningful Use Core Set Questions
Instructions
To qualify for an incentive payment the EP must specify the EHR reporting period, answer the general questions below and attest to all 15 required Core objectives.
#
Measure
EHR Reporting Period
Start Date:
End Date:

Figure 15 - PY2 EHR Reporting Period

Payment Years 3-6

If you have previously attested to Meaningful Use (you are in your third, fourth, fifth or sixth payment year): Your reporting period is "the calendar year." per 42 CFR § 495.4 (1)(ii)(A). You will not be able to begin Meaningful Use attestation until the entire calendar year being used as your reporting period has passed.

The system will display the same calendar tool you used in the previous year. Use this calendar to select your reporting period year.

Note: Once you input data you must exit the field for additional questions to display. Some additional questions are displayed based on your answers.

General Questions

To be a meaningful user, at least 80% of unique patients must have their data in the certified EHR during the EHR reporting period.

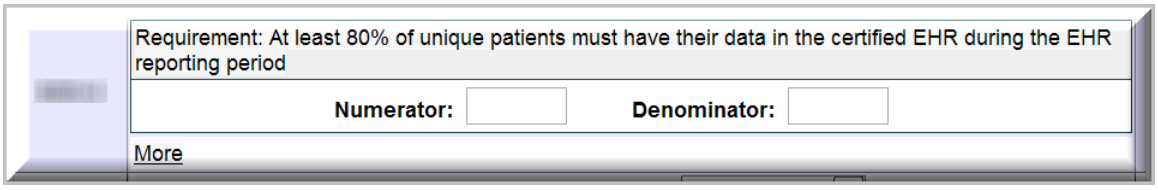

Requirement: At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period
Numerator:
Denominator:
More

Figure 16 - MU General 80% Question

If you practice in multiple locations, the addresses you entered in the Provider Questions page are displayed here. Answer the question and provide numerators and denominators for each location.

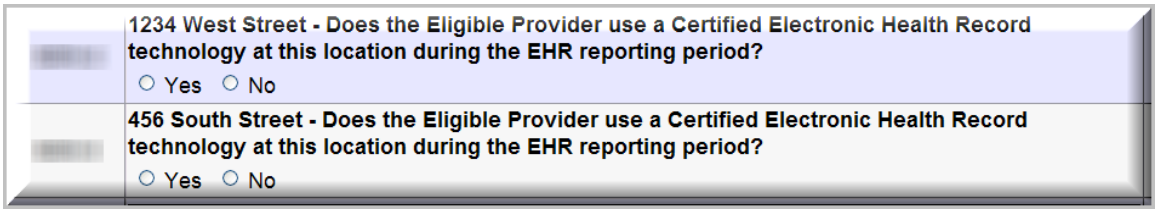

1234 West Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?
Yes
No
456 South Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?
Yes
No

Figure 17 - MU Multiple Location Question

You must select the principal county in which you practice.

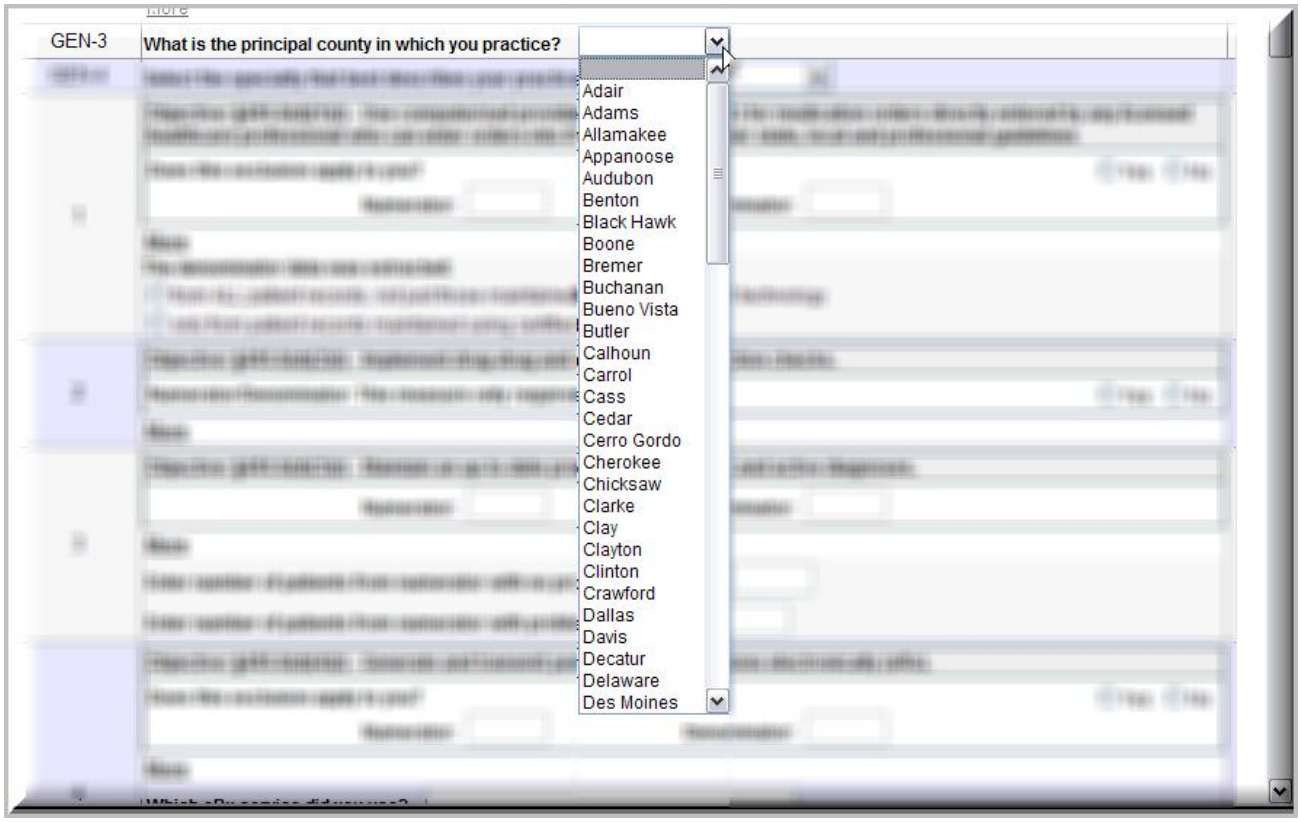


Figure 18 - Principal County

You must select the specialty that best describes your practice.

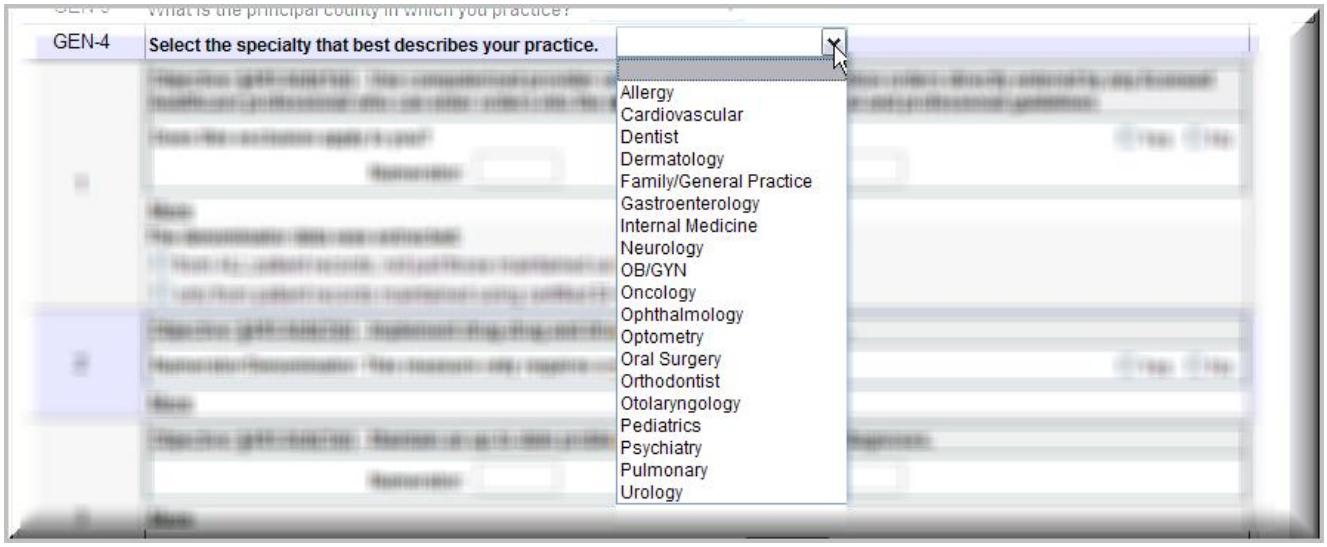


Figure 19 – Specialty

2.4.2.2 *EP Core Objectives*

An EP must attest to all 15 Core objectives. Attestation for most objectives is accomplished by entering a numerator, denominator and exclusion information. Certain objectives do not require a numerator and denominator, but rather a Yes/No answer. Objectives that require the denominator type will display the types of denominators allowed, you must select a denominator source. All questions require an answer unless otherwise specified.

All Meaningful Use objectives are displayed in a similar fashion. Review the section below prior to beginning attestation to become familiar with the MU questions.

Due to the nature of the program, not all of the MU objectives and associated measures are described in detail in this manual. The objectives and measures may change according to new federal regulations, and will change depending on the stage of MU you are attesting to. Please refer to the final rule, www.healthit.hhs.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

Objective

The top row displays the objective number and text from 42 CFR § 495 to allow you to easily locate the objective in the final rule for any clarifications you may need.

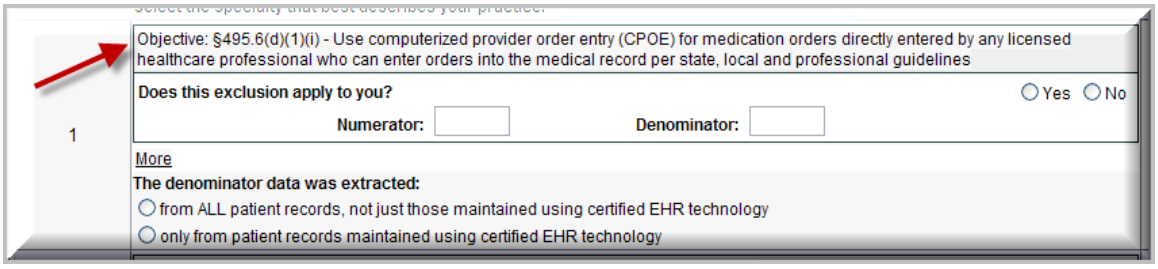

Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
Does this exclusion apply to you?
Yes
No
1
Numerator:
Denominator:
More
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

Figure 20 - Objective Description

Answer

The second section of the question box contains the quick view of the required information in order to attest to meeting the measure requirements.

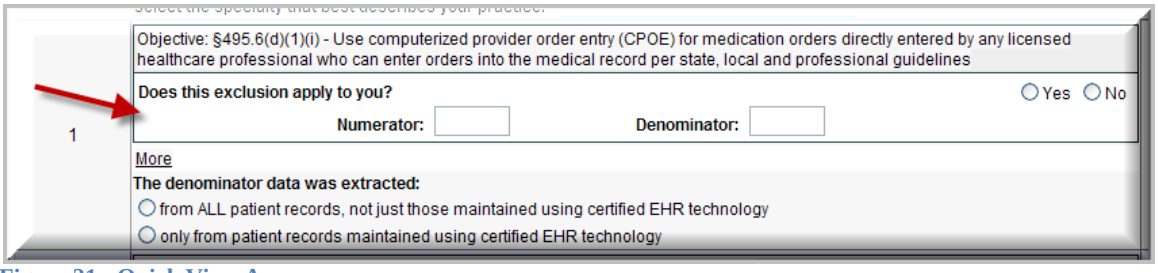

Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
Does this exclusion apply to you?
Yes
No
1
Numerator:
Denominator:
More
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

Figure 21 - Quick View Answers

More link

The 'More' link will expand the Answer box to provide detailed information on the measure for the objective. Details about the exclusion (if applicable) are displayed, as well as details for the numerator and denominator.

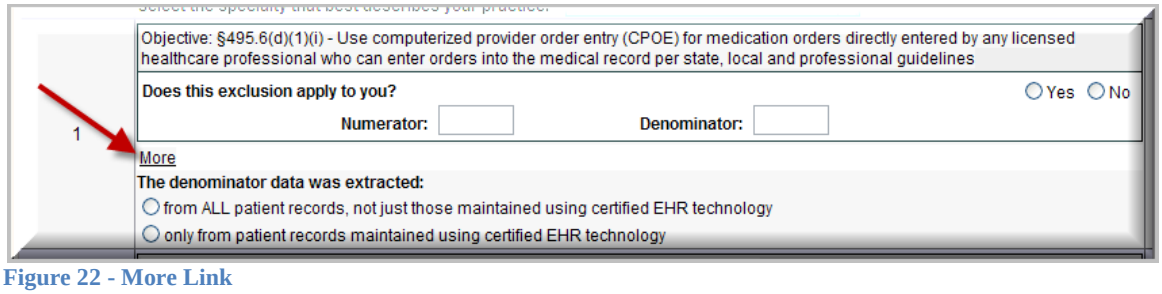
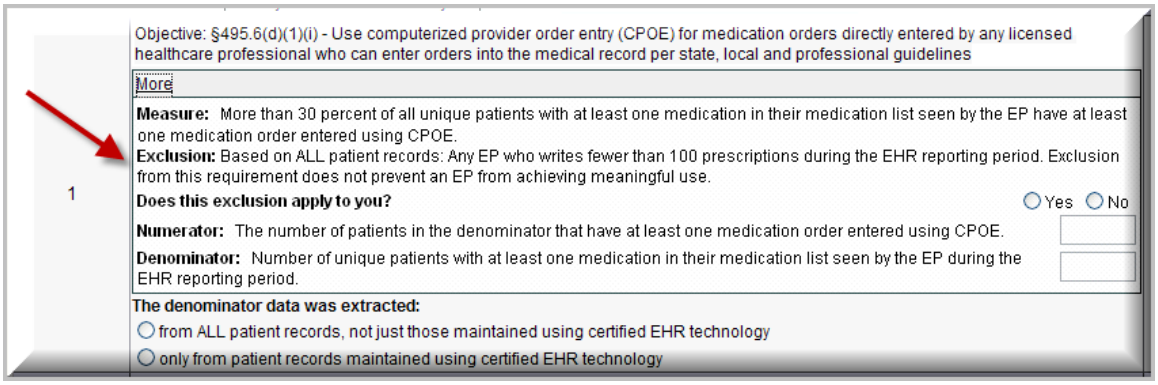
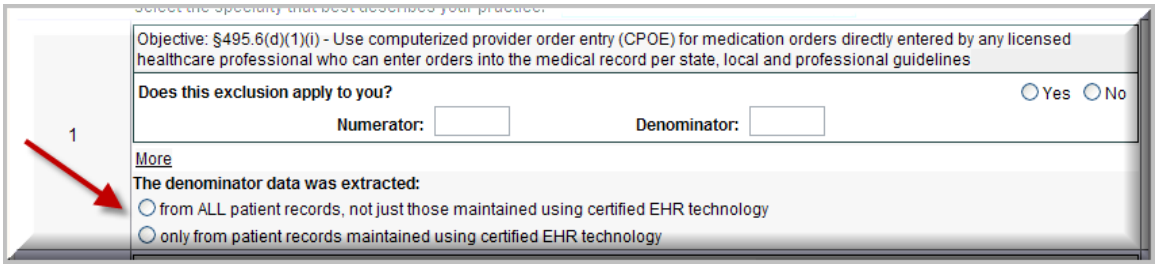

Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
Does this exclusion apply to you?
Yes
No
1
Numerator:
Denominator:
More
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

Figure 22 - More Link


Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
More
Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
1
Does this exclusion apply to you?
Yes
No
Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology
Figure 23 - Expanded More Link

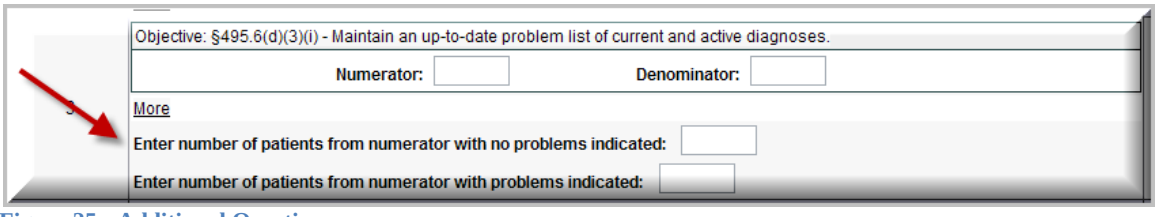
Denominator Type

For objectives that require the type of denominator you used to produce your MU data, an additional section displays for you to indicate the source of your denominator.


Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
Does this exclusion apply to you?
Yes
No
1
Numerator:
Denominator:
More
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology
Figure 24 - Denominator Source

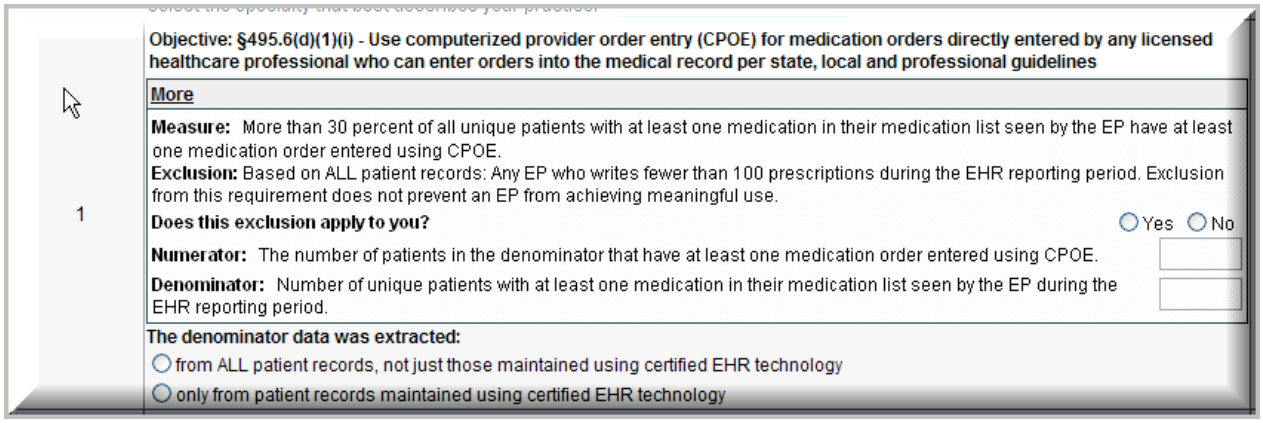
Additional Questions

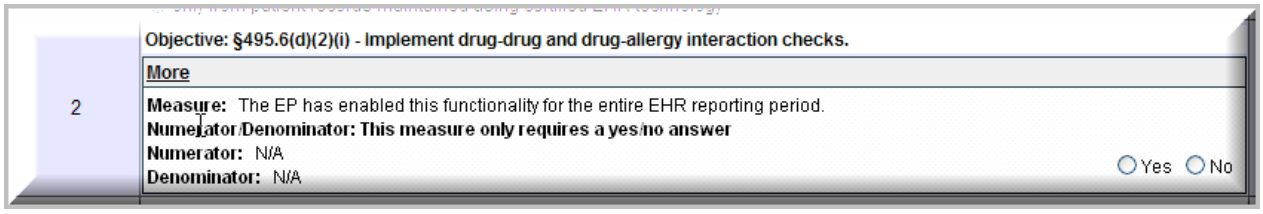
Some objectives require you to provide additional information about your answer. These questions vary by objective and your answers. Please keep an eye out for these as you attest to MU. If the question is displayed an answer is required.

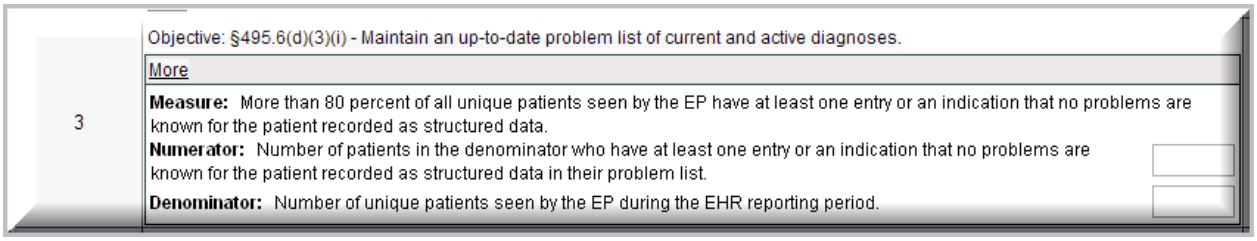

Objective: §495.6(d)(3)(i) - Maintain an up-to-date problem list of current and active diagnoses.
Numerator:
Denominator:
More
Enter number of patients from numerator with no problems indicated:
Enter number of patients from numerator with problems indicated:
Figure 25 - Additional Questions

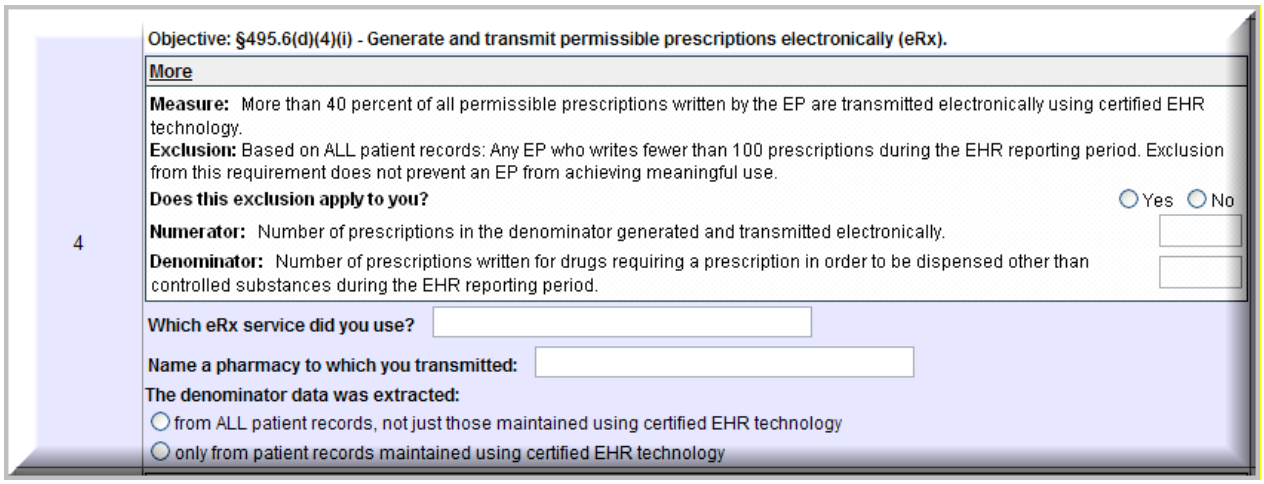
Meaningful Use Core Set Questions

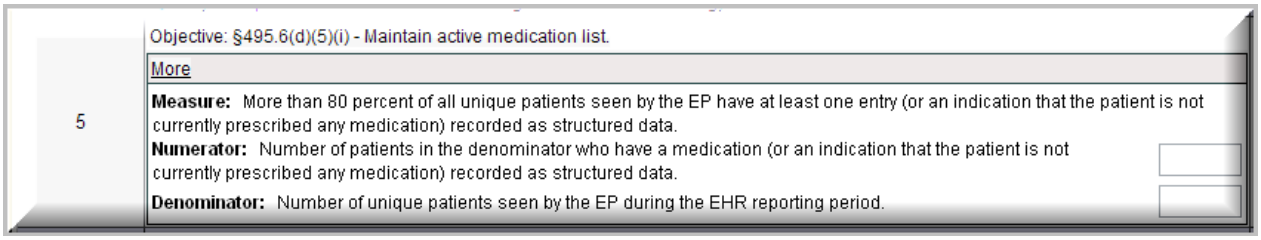
2.4.2.3 *EP Core Set Screen Shots*

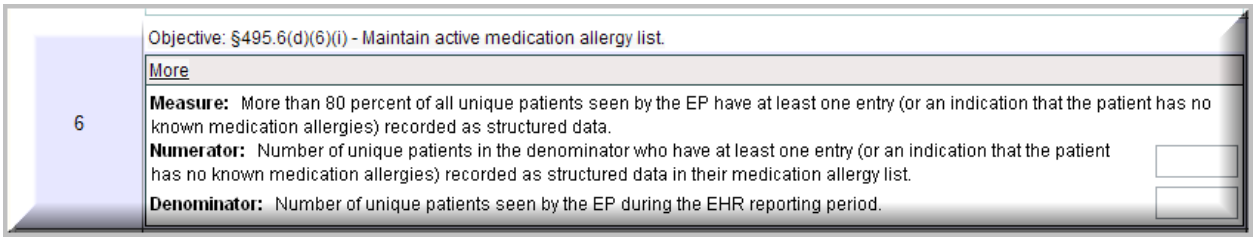

1
Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
More
Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
Does this exclusion apply to you?
Yes
No
Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

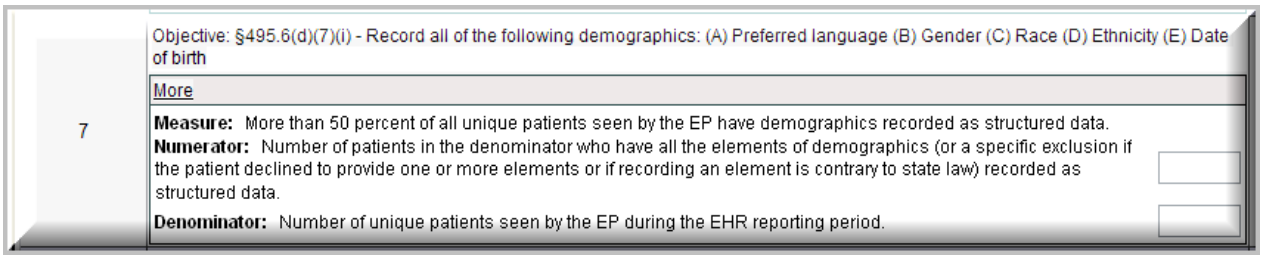

2
Objective: §495.6(d)(2)(i) - Implement drug-drug and drug-allergy interaction checks.
More
Measure: The EP has enabled this functionality for the entire EHR reporting period.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes
No

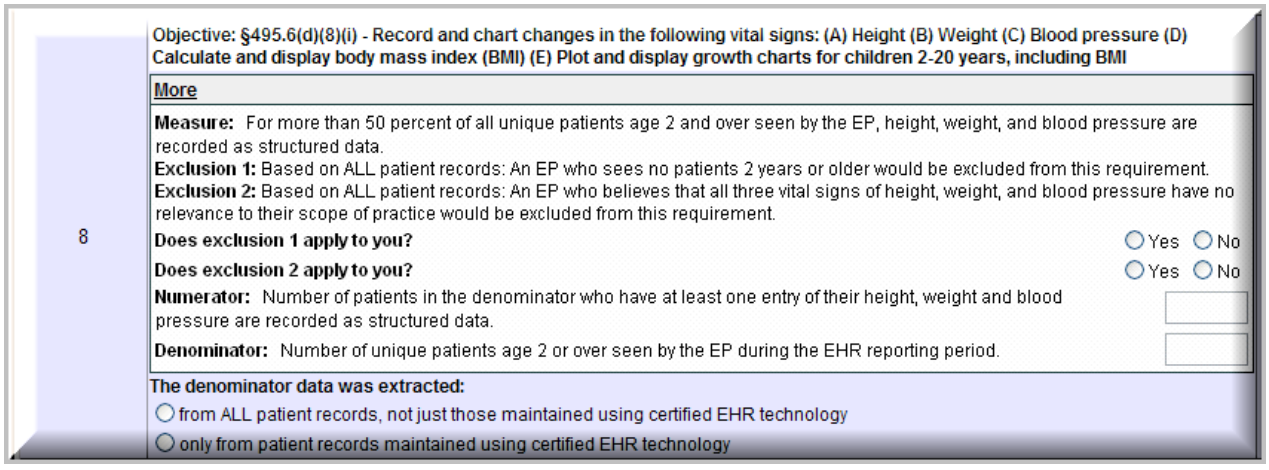

3
Objective: §495.6(d)(3)(i) - Maintain an up-to-date problem list of current and active diagnoses.
More
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Numerator: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.

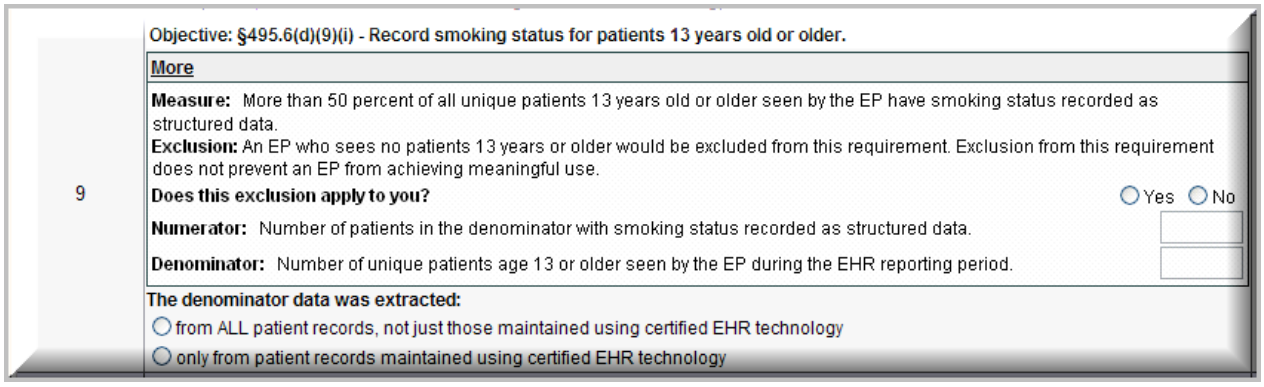

4
Objective: §495.6(d)(4)(i) - Generate and transmit permissible prescriptions electronically (eRx).
More
Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
Does this exclusion apply to you?
Yes
No
Numerator: Number of prescriptions in the denominator generated and transmitted electronically.
Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
Which eRx service did you use?
Name a pharmacy to which you transmitted:
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

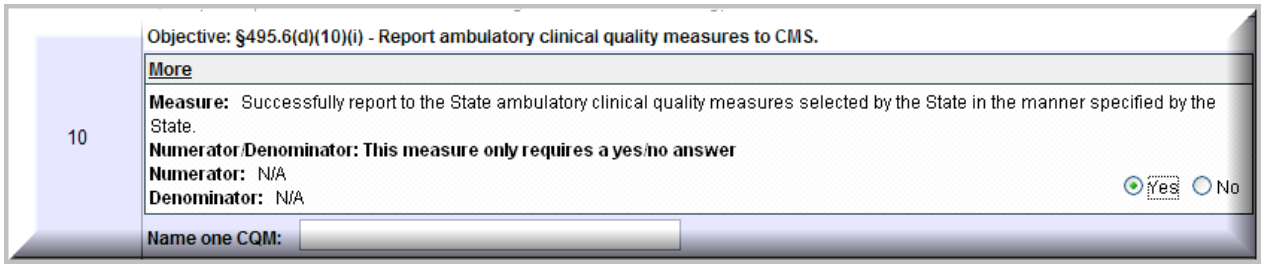

5
Objective: §495.6(d)(5)(i) - Maintain active medication list.
More
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Numerator: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.

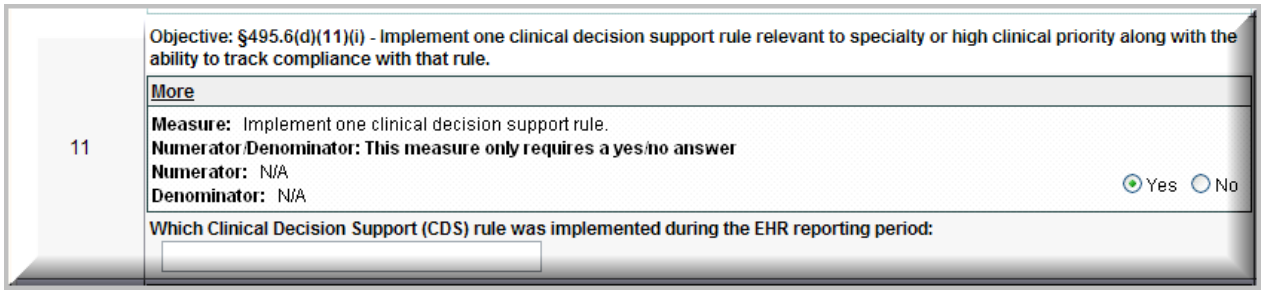

6
Objective: §495.6(d)(6)(i) - Maintain active medication allergy list.
More
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Numerator: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.

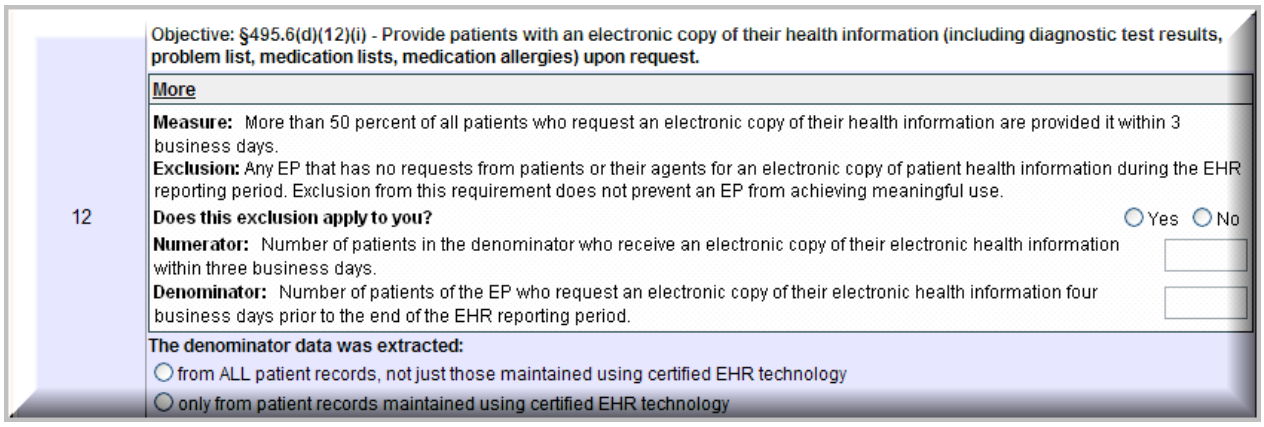

7
Objective: §495.6(d)(7)(i) - Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth
More
Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Numerator: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.

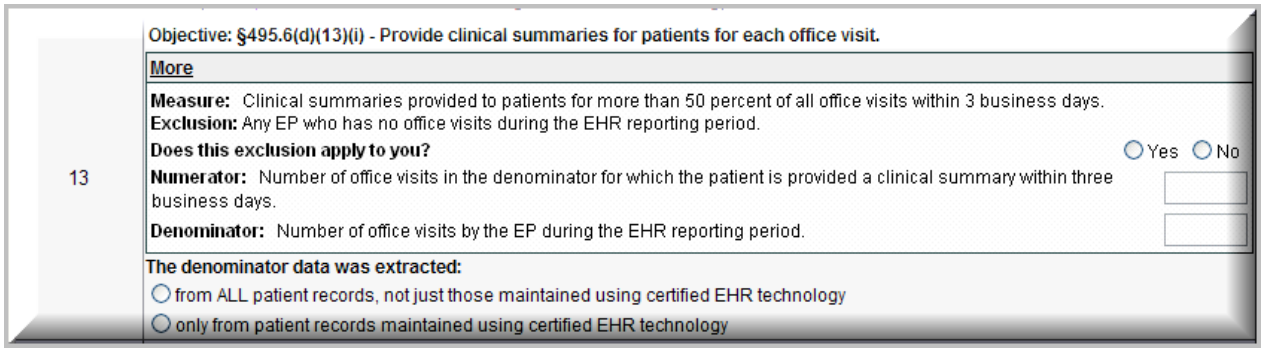

8
Objective: §495.6(d)(8)(i) - Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI
More
Measure: For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.
Exclusion 1: Based on ALL patient records: An EP who sees no patients 2 years or older would be excluded from this requirement.
Exclusion 2: Based on ALL patient records: An EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this requirement.
Does exclusion 1 apply to you?
Yes
No
Does exclusion 2 apply to you?
Yes
No
Numerator: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.
Denominator: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

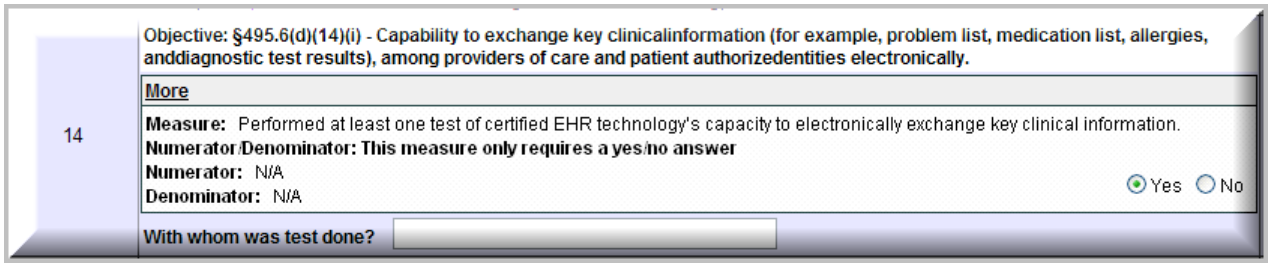

9
Objective: §495.6(d)(9)(i) - Record smoking status for patients 13 years old or older.
More
Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion: An EP who sees no patients 13 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
Does this exclusion apply to you?
Yes
No
Numerator: Number of patients in the denominator with smoking status recorded as structured data.
Denominator: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

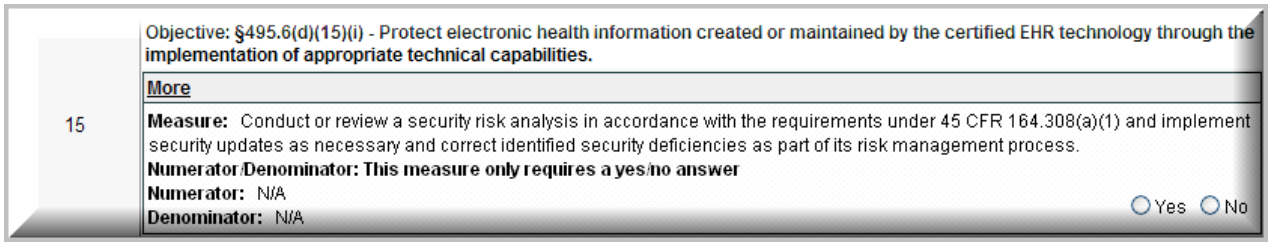

10
Objective: §495.6(d)(10)(i) - Report ambulatory clinical quality measures to CMS.
More
Measure: Successfully report to the State ambulatory clinical quality measures selected by the State in the manner specified by the State.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes
No
Name one CQM:


11
Objective: §495.6(d)(11)(i) - Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
More
Measure: Implement one clinical decision support rule.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes
No
Which Clinical Decision Support (CDS) rule was implemented during the EHR reporting period:


12
Objective: §495.6(d)(12)(i) - Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
More
Measure: More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
Exclusion: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
Does this exclusion apply to you?
Yes
No
Numerator: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
Denominator: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology


13
Objective: §495.6(d)(13)(i) - Provide clinical summaries for patients for each office visit.
More
Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion: Any EP who has no office visits during the EHR reporting period.
Does this exclusion apply to you?
Yes
No
Numerator: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
Denominator: Number of office visits by the EP during the EHR reporting period.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology


14
Objective: §495.6(d)(14)(i) - Capability to exchange key clinicalinformation (for example, problem list, medication list, allergies, anddiagnostic test results), among providers of care and patient authorizedentities electronically.
More
Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes
No
With whom was test done?


15
Objective: §495.6(d)(15)(i) - Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
More
Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes
No

2.4.2.4 *EP Menu Objectives*

An EP must choose a total of 5 Meaningful Use Menu objectives. At least one of the 5 objectives must be public health objectives (495.6(e)(9) or 495.6(e)(10)). If you can attest to exclusions for both public health objectives, you must choose one of the two objectives and attest to the exclusion.

If the EP can claim an exclusion to an objective, as long as the EP meets the criteria to claim the exclusion and attests to the exclusion, the objective is counted toward the 5 menu set objectives that are required. EPs are encouraged to select objectives they are able to report on, where the exclusion does not apply to them.

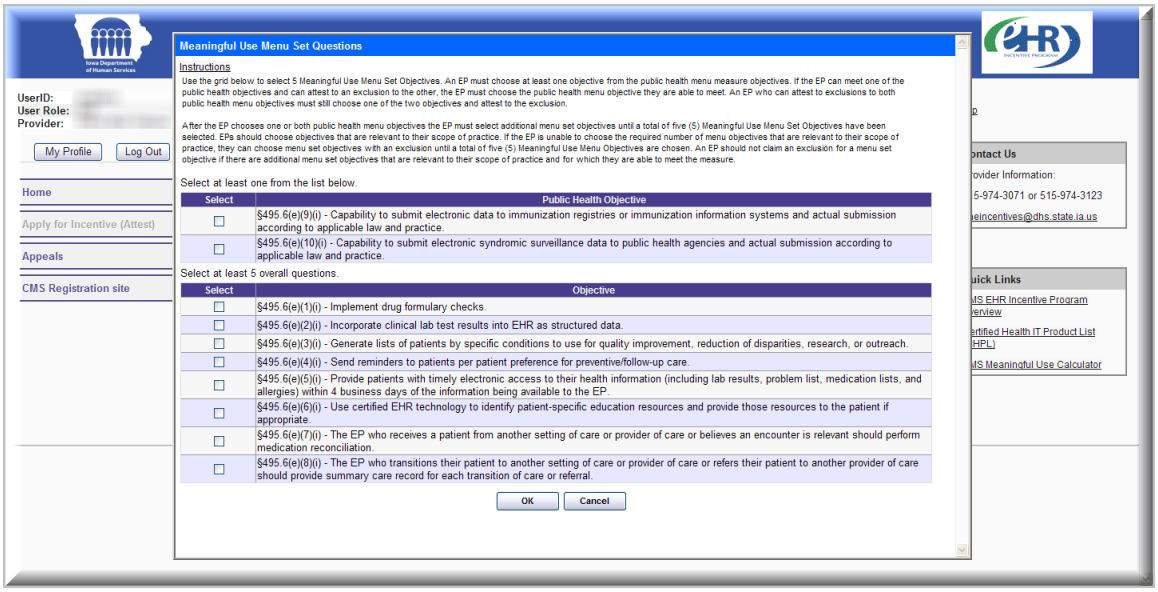

Meaningful Use Menu Set Questions
Instructions
Use the grid below to select 5 Meaningful Use Menu Set Objectives. An EP must choose at least one objective from the public health menu measure objectives. If the EP can meet one of the public health objectives and can attest to an exclusion to the other, the EP must choose the public health menu objective they are able to meet. An EP who can attest to exclusions to both public health menu objectives must still choose one of the two objectives and attest to the exclusion.
After the EP chooses one or both public health menu objectives the EP must select additional menu set objectives until a total of five (5) Meaningful Use Menu Set Objectives have been selected. EPs should choose objectives that are relevant to their scope of practice. If the EP is unable to choose the required number of menu objectives that are relevant to their scope of practice, they can choose menu set objectives with an exclusion until a total of five (5) Meaningful Use Menu Objectives are chosen. An EP should not claim an exclusion for a menu set objective if there are additional menu set objectives that are relevant to their scope of practice and for which they are able to meet the measure.
Select at least one from the list below.
Select
Public Health Objective
§495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
§495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
Select at least 5 overall questions.
Select
Objective
§495.6(e)(1)(i) - Implement drug formulary checks.
§495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
§495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
§495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care.
§495.6(e)(5)(i) - Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
§495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
§495.6(e)(7)(i) - The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
§495.6(e)(8)(i) - The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site

Figure 26 – EP MU Menu Selection

2.4.2.4.1 *Menu Objective Selection*

To access the Meaningful Use Menu Set Questions, click on the 'Attest' link next to the Criteria name 'Meaningful Use Menu Set Questions'.

The EP Core Objective section above provides guidelines similar to those in this section of the manual.

The grids displayed list the menu set objectives. The top portion of the grid contains the public health objectives. The bottom portion of the grid contains the additional menu objectives.

Use the checkboxes on the left of the objectives to select the objective. You must select at least 5 objectives to attest to; at least one of those objectives must be from the top section of the grid – the public health objectives.

Please select the objectives carefully. Once you select your menu objectives the system will display a screen that will allow you enter your attestation data. You will not be able to save some of your objective measure data and return to the selection screen to change the objectives you elected to attest to.

The menu objectives are displayed in the same manner the core objectives. Refer to section 2.4.2.2 for the layout of the objectives and measures.

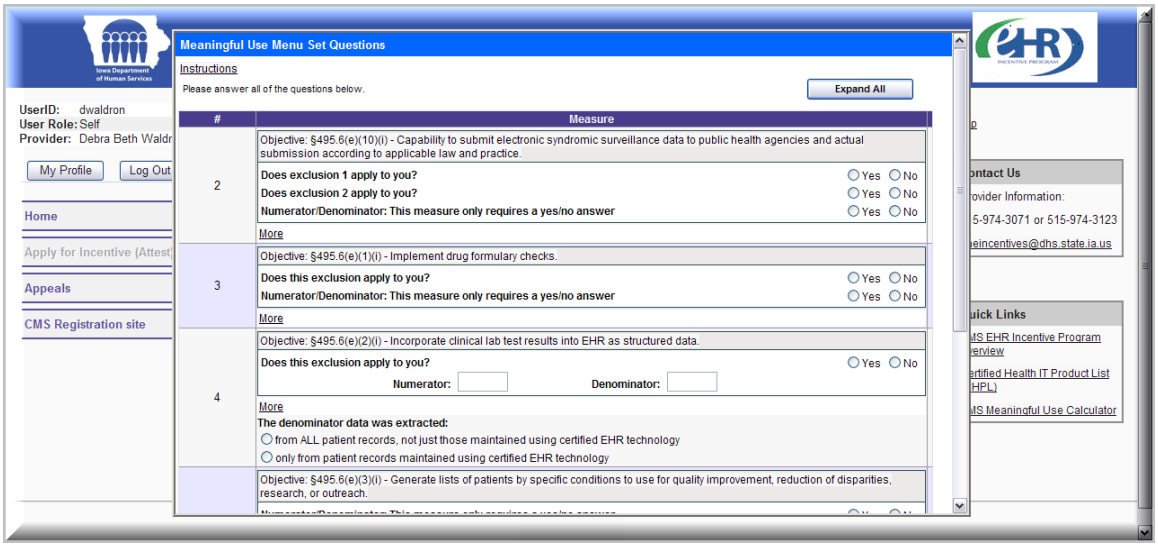
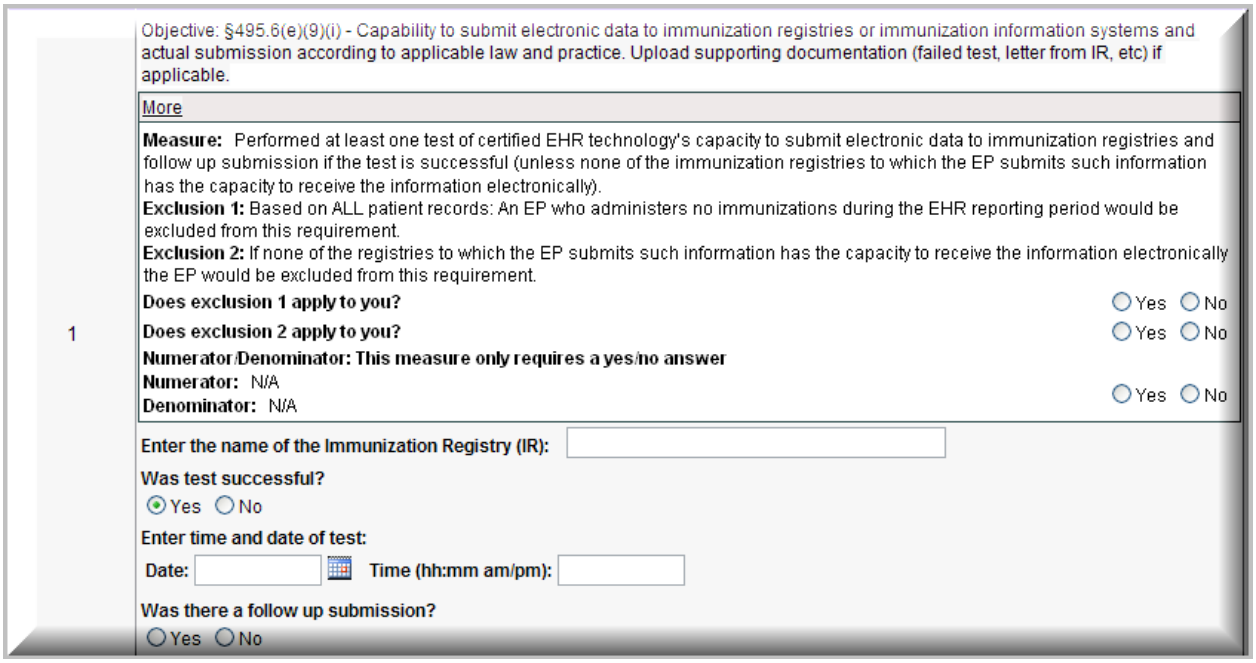
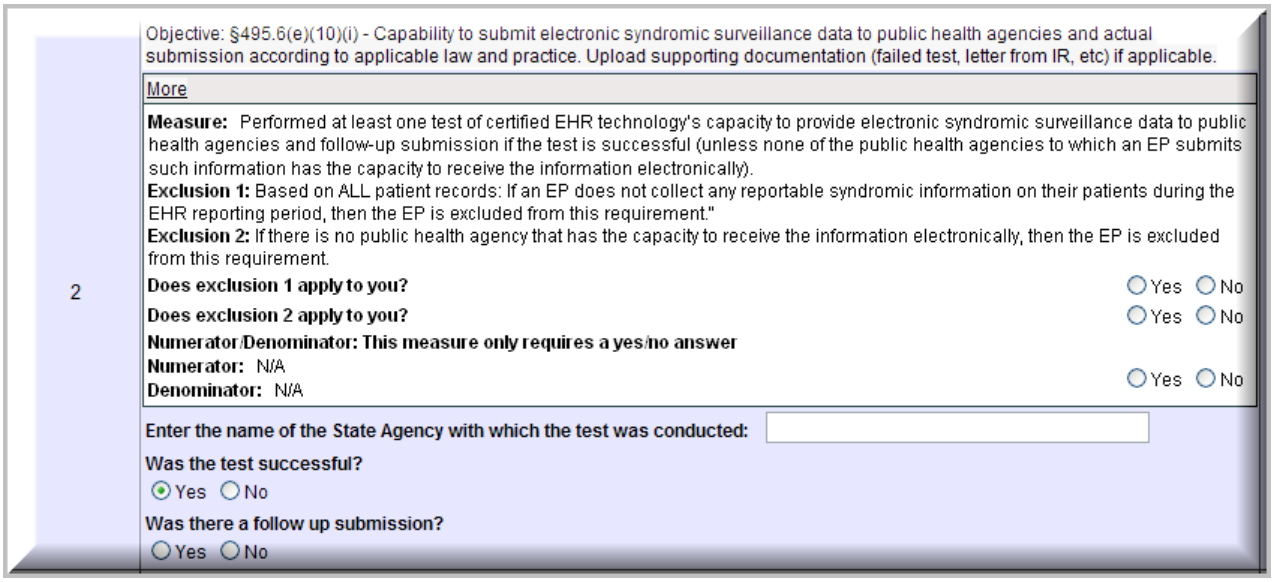
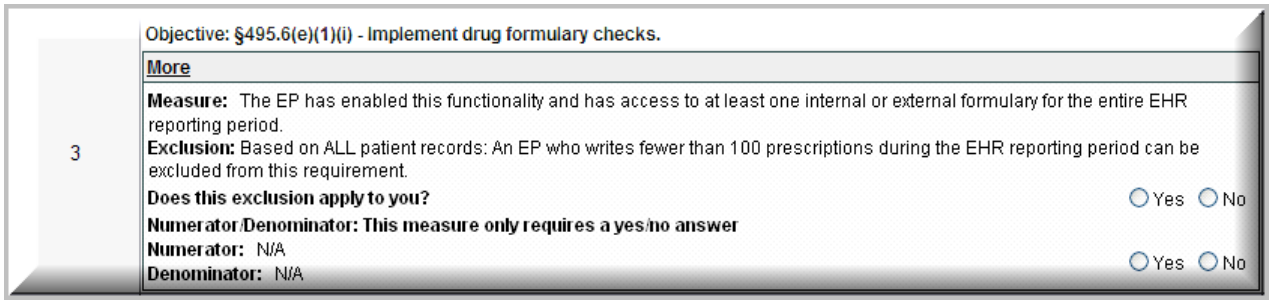

Meaningful Use Menu Set Questions
Instructions
Please answer all of the questions below.
Expand All
UserID: dwaldron
User Role: Self
Provider: Debra Beth Waldr
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
#
Measure
2
Objective: §495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
Does exclusion 1 apply to you? Yes No
Does exclusion 2 apply to you? Yes No
Numerator/Denominator: This measure only requires a yes/no answer Yes No
More
3
Objective: §495.6(e)(1)(i) - Implement drug formulary checks.
Does this exclusion apply to you? Yes No
Numerator/Denominator: This measure only requires a yes/no answer Yes No
More
4
Objective: §495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
Does this exclusion apply to you? Yes No
Numerator:
Denominator:
More
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology
Objective: §495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
meincentives@dhs.state.ia.us
Quick Links
MS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
MS Meaningful Use Calculator

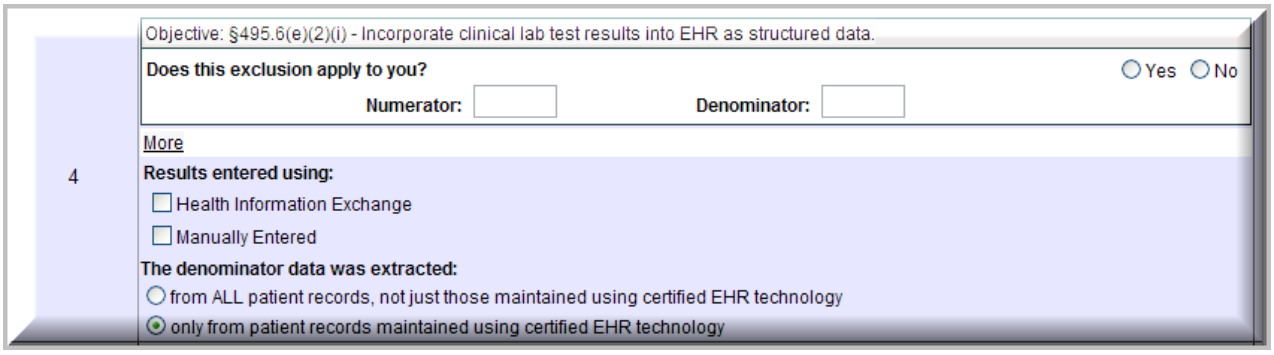
Figure 27 - EP MU Menu Objectives

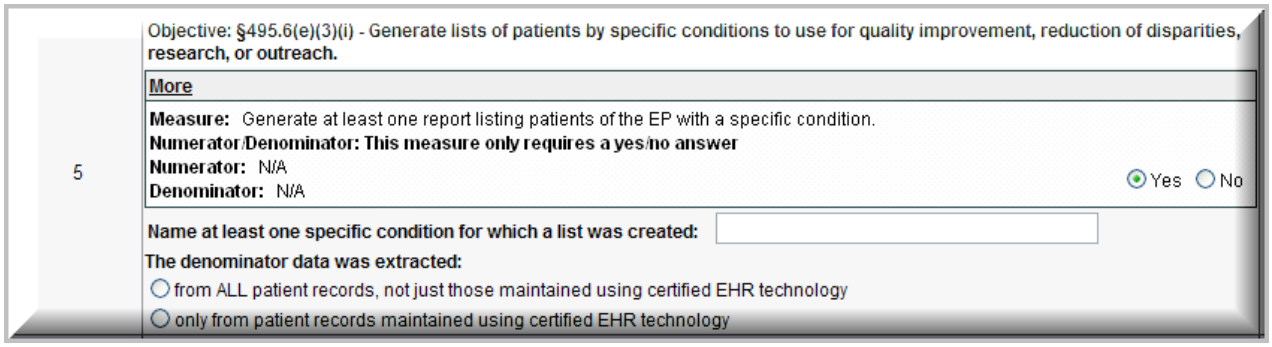
2.4.2.5 *Menu Set Question Screen Shots*

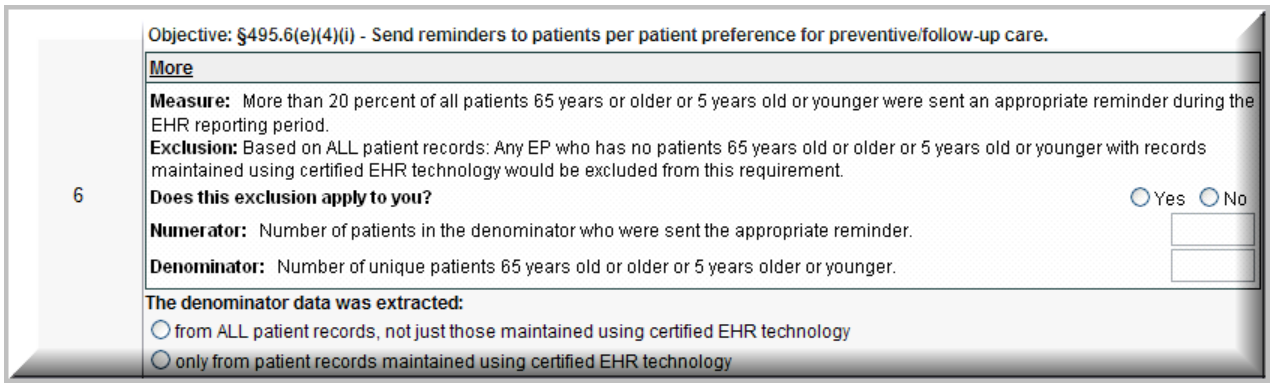

Objective: §495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. Upload supporting documentation (failed test, letter from IR, etc) if applicable.
More
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).
Exclusion 1: Based on ALL patient records: An EP who administers no immunizations during the EHR reporting period would be excluded from this requirement.
Exclusion 2: If none of the registries to which the EP submits such information has the capacity to receive the information electronically the EP would be excluded from this requirement.
Does exclusion 1 apply to you? Yes No
1
Does exclusion 2 apply to you? Yes No
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A Yes No
Enter the name of the Immunization Registry (IR):
Was test successful?
Yes No
Enter time and date of test:
Date:
Time (hh:mm am/pm):
Was there a follow up submission?
Yes No

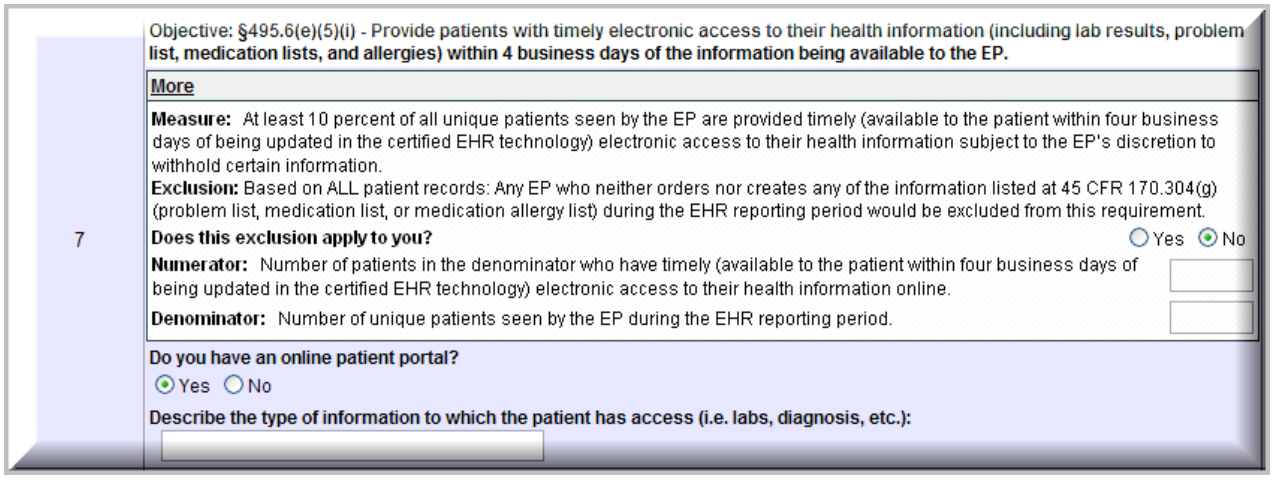

2
Objective: §495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. Upload supporting documentation (failed test, letter from IR, etc) if applicable.
More
Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).
Exclusion 1: Based on ALL patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EP is excluded from this requirement."
Exclusion 2: If there is no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement.
Does exclusion 1 apply to you? Yes No
Does exclusion 2 apply to you? Yes No
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes No
Enter the name of the State Agency with which the test was conducted:
Was the test successful?
Yes No
Was there a follow up submission?
Yes No

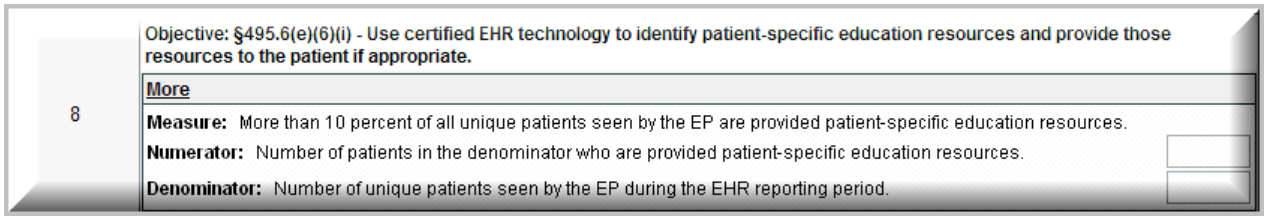

3
Objective: §495.6(e)(1)(i) - Implement drug formulary checks.
More
Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion: Based on ALL patient records: An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement.
Does this exclusion apply to you? Yes No
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes No

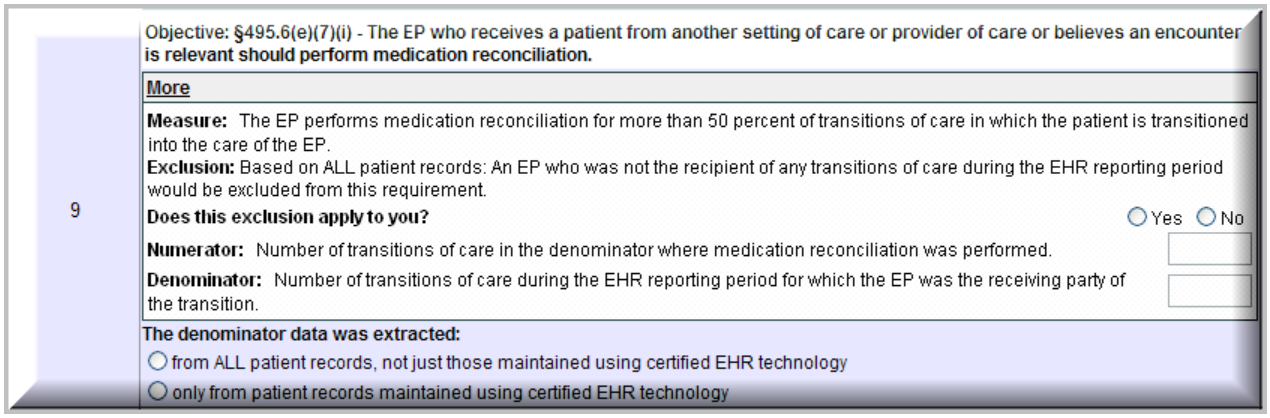

4
Objective: §495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
Does this exclusion apply to you? Yes No
Numerator:
Denominator:
More
Results entered using:
Health Information Exchange
Manually Entered
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

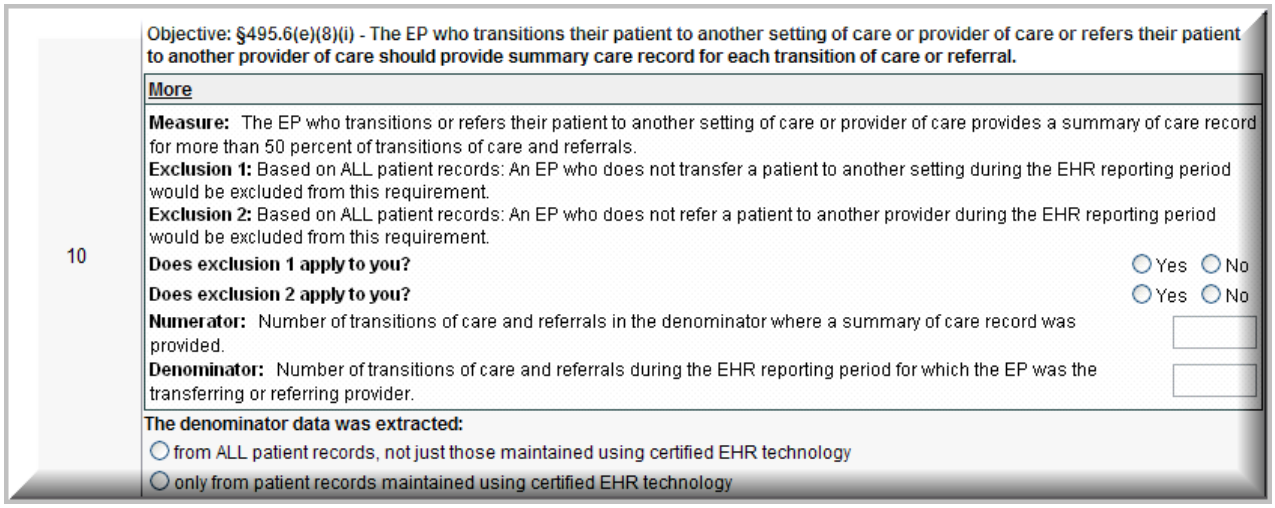

5
Objective: §495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
More
Measure: Generate at least one report listing patients of the EP with a specific condition.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A
Yes No
Name at least one specific condition for which a list was created:
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology


6
Objective: §495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care.
More
Measure: More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion: Based on ALL patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology would be excluded from this requirement.
Does this exclusion apply to you?
Yes No
Numerator: Number of patients in the denominator who were sent the appropriate reminder.
Denominator: Number of unique patients 65 years old or older or 5 years older or younger.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology


7
Objective: §495.6(e)(5)(i) - Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
More
Measure: At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
Exclusion: Based on ALL patient records: Any EP who neither orders nor creates any of the information listed at 45 CFR 170.304(g) (problem list, medication list, or medication allergy list) during the EHR reporting period would be excluded from this requirement.
Does this exclusion apply to you?
Yes No
Numerator: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
Do you have an online patient portal?
Yes No
Describe the type of information to which the patient has access (i.e. labs, diagnosis, etc.):


8
Objective: §495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
More
Measure: More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Numerator: Number of patients in the denominator who are provided patient-specific education resources.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.


9
Objective: §495.6(e)(7)(i) - The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
More
Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion: Based on ALL patient records: An EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from this requirement.
Does this exclusion apply to you?
Yes No
Numerator: Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology


10
Objective: §495.6(e)(8)(i) - The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
More
Measure: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement.
Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another provider during the EHR reporting period would be excluded from this requirement.
Does exclusion 1 apply to you? Yes No
Does exclusion 2 apply to you? Yes No
Numerator: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
The denominator data was extracted:
from ALL patient records, not just those maintained using certified EHR technology
only from patient records maintained using certified EHR technology

2.4.2.6 *EP Clinical Quality Measures (CQM)*

To qualify for the incentive payment for Stage 1 the EP must attest to a sum total of up to 9 CQMs. Each EP must report on 3 Core CQMs (or 3 Alternate CQMs, if needed), and 3 Additional quality measures. EPs must report calculated CQMs directly from their certified EHR technology

If you can attest to all 3 core CQMs without a zero denominator, you will be prompted to select 3 additional CQMs.

If you attest to any of the 3 core CQMs using a zero denominator; for each core CQM with a zero denominator, you will need to select an equal number of the 3 alternative CQMs. Using this logic you could essentially attest to all 6 core CQMs. Regardless of the number of core CQMs you attest to you will still be required to attest to 3 additional CQMs.

2.4.2.6.1 *EP Clinical Quality Measures Attestation*

To access the Meaningful Use Clinical Quality Measures, click on the 'Attest' link next to the Criteria name 'Meaningful Use Menu Clinical Quality Measures'.

At the top of each screen are instructions similar to those in this section of the manual.

The first screen will display the core CQMs. You must enter data for each of these measures.

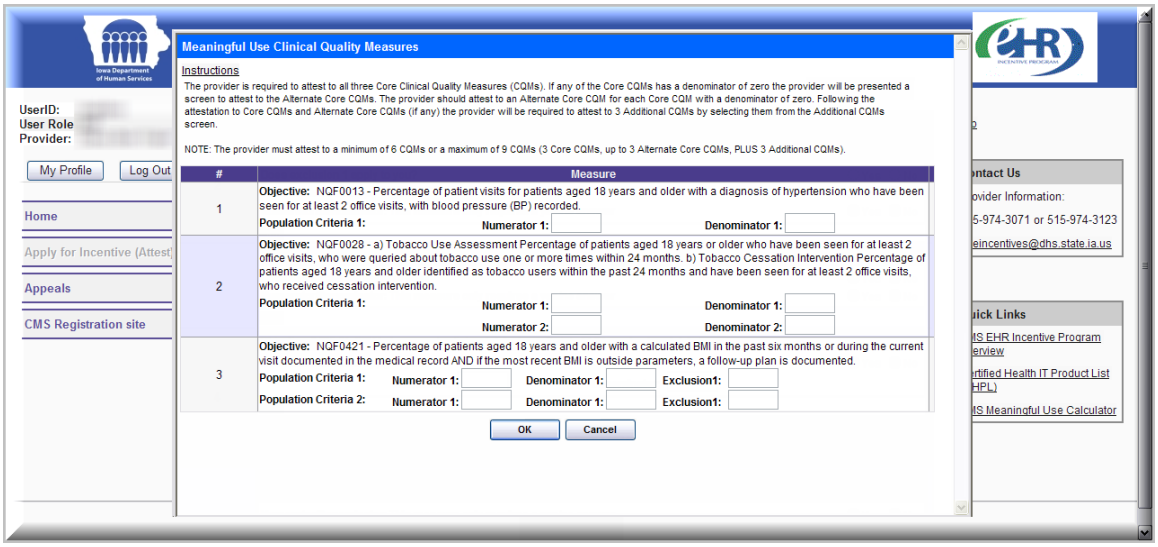

Meaningful Use Clinical Quality Measures
Instructions
The provider is required to attest to all three Core Clinical Quality Measures (CQMs). If any of the Core CQMs has a denominator of zero the provider will be presented a screen to attest to the Alternate Core CQMs. The provider should attest to an Alternate Core CQM for each Core CQM with a denominator of zero. Following the attestation to Core CQMs and Alternate Core CQMs (if any) the provider will be required to attest to 3 Additional CQMs by selecting them from the Additional CQMs screen.
NOTE: The provider must attest to a minimum of 6 CQMs or a maximum of 9 CQMs (3 Core CQMs, up to 3 Alternate Core CQMs, PLUS 3 Additional CQMs).
#
Measure
1
Objective: NQF0013 - Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Population Criteria 1:
Numerator 1:
Denominator 1:
2
Objective: NQF0028 - a) Tobacco Use Assessment Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months. b) Tobacco Cessation Intervention Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
Population Criteria 1:
Numerator 1:
Denominator 1:
Numerator 2:
Denominator 2:
3
Objective: NQF0421 - Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
Population Criteria 1:
Numerator 1:
Denominator 1:
Exclusion1:
Population Criteria 2:
Numerator 1:
Denominator 1:
Exclusion1:
OK
Cancel
UserID:
User Role
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site

Figure 28 - EP MU Core CQMs

2.4.2.6.2 *EP Core CQM Screen Shots*

Objective: NQF0013 - Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.

Population Criteria 1: **Numerator 1:** **Denominator 1:**

Objective: NQF0028 - a) Tobacco Use Assessment Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months. b) Tobacco Cessation Intervention Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

Population Criteria 1: **Numerator 1:** **Denominator 1:**
Numerator 2: **Denominator 2:**

Objective: NQF0421 - Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**
Population Criteria 2: **Numerator 1:** **Denominator 1:** **Exclusion1:**

The alternative core CQMs will only be displayed if you have attested to any of the core CQMs with a zero denominator.

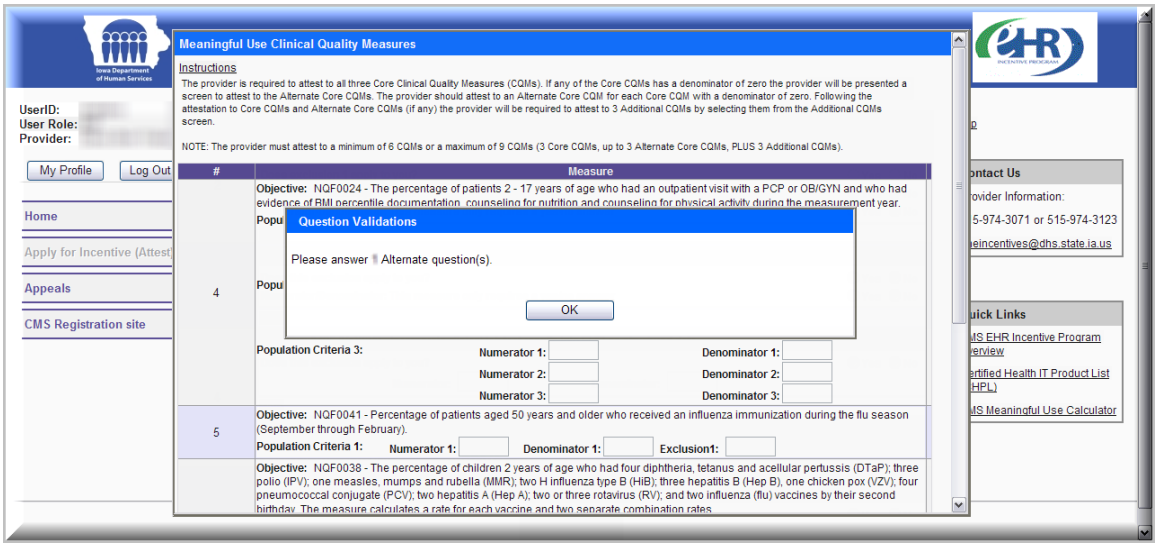

Meaningful Use Clinical Quality Measures
Instructions
The provider is required to attest to all three Core Clinical Quality Measures (CQMs). If any of the Core CQMs has a denominator of zero the provider will be presented a screen to attest to the Alternate Core CQMs. The provider should attest to an Alternate Core CQM for each Core CQM with a denominator of zero. Following the attestation to Core CQMs and Alternate Core CQMs (if any) the provider will be required to attest to 3 Additional CQMs by selecting them from the Additional CQMs screen.
NOTE: The provider must attest to a minimum of 6 CQMs or a maximum of 9 CQMs (3 Core CQMs, up to 3 Alternate Core CQMs, PLUS 3 Additional CQMs).
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
#
Measure
Objective: NQF0024 - The percentage of patients 2 - 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
Question Validations
Please answer Alternate question(s).
OK
4
Population Criteria 3:
Numerator 1:
Denominator 1:
Numerator 2:
Denominator 2:
Numerator 3:
Denominator 3:
5
Objective: NQF0041 - Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
Population Criteria 1:
Numerator 1:
Denominator 1:
Exclusion1:
Objective: NQF0038 - The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
eincentives@dhs.state.ia.us
Quick Links
MS EHR Incentive Program
erview
ertified Health IT Product List
HPL)
MS Meaningful Use Calculator

Figure 29 - EP MU Alternate Core CQMs

2.4.2.6.3 *EP Alternate Core CQM Screen Shots*

Objective: NQF0024 - The percentage of patients 2 - 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Population Criteria 1:	**Numerator 1:**	**Denominator 1:**
	Numerator 2:	**Denominator 2:**
	Numerator 3:	**Denominator 3:**
Population Criteria 2:	**Numerator 1:**	**Denominator 1:**
	Numerator 2:	**Denominator 2:**
	Numerator 3:	**Denominator 3:**
Population Criteria 3:	**Numerator 1:**	**Denominator 1:**
	Numerator 2:	**Denominator 2:**
	Numerator 3:	**Denominator 3:**

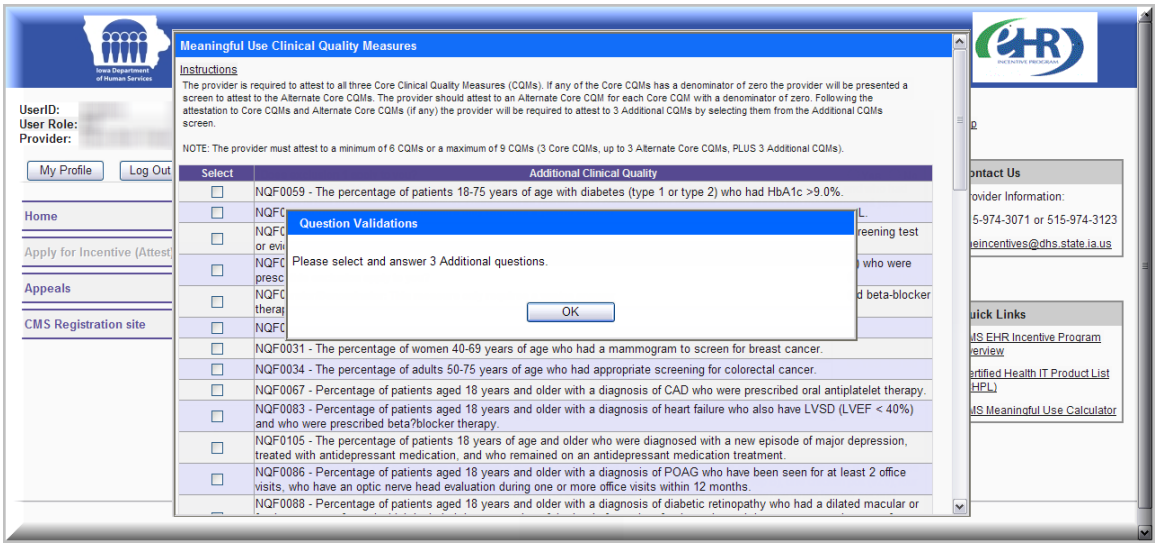
Objective: NQF0041 - Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0038 - The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Population Criteria 1:	**Numerator 1:**	**Denominator 1:**
	Numerator 2:	**Denominator 2:**
	Numerator 3:	**Denominator 3:**
	Numerator 4:	**Denominator 4:**
	Numerator 5:	**Denominator 5:**
	Numerator 6:	**Denominator 6:**
	Numerator 7:	**Denominator 7:**
	Numerator 8:	**Denominator 8:**
	Numerator 9:	**Denominator 9:**
	Numerator 10:	**Denominator 10:**
	Numerator 11:	**Denominator 11:**
	Numerator 12:	**Denominator 12:**

Once you have satisfied the core CQM requirements, you will be prompted to select 3 additional CQMs.


Meaningful Use Clinical Quality Measures
Instructions
The provider is required to attest to all three Core Clinical Quality Measures (CQMs). If any of the Core CQMs has a denominator of zero the provider will be presented a screen to attest to the Alternate Core CQMs. The provider should attest to an Alternate Core CQM for each Core CQM with a denominator of zero. Following the attestation to Core CQMs and Alternate Core CQMs (if any) the provider will be required to attest to 3 Additional CQMs by selecting them from the Additional CQMs screen.
NOTE: The provider must attest to a minimum of 6 CQMs or a maximum of 9 CQMs (3 Core CQMs, up to 3 Alternate Core CQMs, PLUS 3 Additional CQMs).
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Select
Additional Clinical Quality
NQF0059 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.
Question Validations
Please select and answer 3 Additional questions.
OK
NQF0031 - The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
NQF0034 - The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
NQF0067 - Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
NQF0083 - Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta?blocker therapy.
NQF0105 - The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
NQF0086 - Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.
NQF0088 - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or
Contact Us
Quick Links
Figure 30 - EP MU Additional CQMs

2.4.2.6.4 *EP Additional CQM Screen Shots*

Objective: NQF0059 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0064 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL?C <100mg/dL.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**
Numerator 2: **Denominator 2:** **Exclusion1:**

Objective: NQF0062 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy .
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0081 - Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0070 - Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0043 - The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0031 - The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0034 - The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0067 - Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0083 - Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta?blocker therapy.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0105 - The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Population Criteria 1: **Numerator 1:** **Denominator 1:**
Numerator 2: **Denominator 2:**

Objective: NQF0086 - Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0088 - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0089 - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0047 - Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:** **Exclusion2:**

Objective: NQF0001 - Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

Population Criteria 1: **Numerator 1:** **Denominator 1:**

Objective: NQF0002 - The percentage of children 2?18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Population Criteria 1: **Numerator 1:** **Denominator 1:**

Objective: NQF0387 - Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12?month reporting period.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0385 - Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0389 - Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0027 - The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

Population Criteria 1: **Numerator 1:** **Denominator 1:**
Numerator 2: **Denominator 2:**

Objective: NQF0055 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0061 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.

Population Criteria 1: **Numerator 1:** **Denominator 1:** **Exclusion1:**

Objective: NQF0056 - The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0074 - Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0084 - Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0073 - The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

Population Criteria 1:	Numerator 1:	Denominator 1:

Objective: NQF0068 - The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.

Population Criteria 1:	Numerator 1:	Denominator 1:

Objective: NQF0004 - The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Population Criteria 1:	Numerator 1:	Denominator 1:
Population Criteria 2:	Numerator 1:	Denominator 1:
	Numerator 2:	Denominator 2:
Population Criteria 1:	Numerator 1:	Denominator 1:

Objective: NQF0012 - Percentage of patients, regardless of age, who gave birth during a 12 month period who were screened for HIV infection during the first or second prenatal visit.

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0014 - Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0018 - The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

Population Criteria 1:	Numerator 1:	Denominator 1:

Objective: NQF0032 - The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

Population Criteria 1:	Numerator 1:	Denominator 1:

Objective: NQF0033 - The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

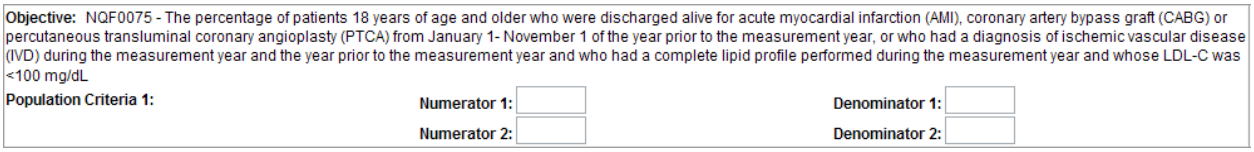
Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:
Population Criteria 2:	Numerator 1:	Denominator 1:	Exclusion1:
Population Criteria 3:	Numerator 1:	Denominator 1:	Exclusion1:

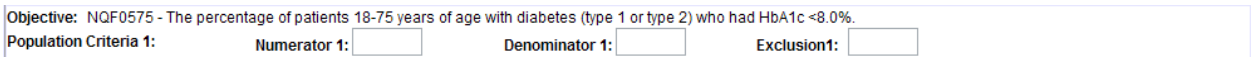
Objective: NQF0036 - The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).

Population Criteria 1:	Numerator 1:	Denominator 1:	Exclusion1:
Population Criteria 2:	Numerator 1:	Denominator 1:	Exclusion1:
Population Criteria 3:	Numerator 1:	Denominator 1:	Exclusion1:

Objective: NQF0052 - The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

Population Criteria 1:	Numerator 1:	Denominator 1:


Objective: NQF0075 - The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL
Population Criteria 1:
Numerator 1:
Denominator 1:
Numerator 2:
Denominator 2:


Objective: NQF0575 - The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.
Population Criteria 1:
Numerator 1:
Denominator 1:
Exclusion1:

Once all the attestation pages have been completed you are ready to submit. See section 2.4.5.

2.4.3 **EH Provider Attestation Information (YEAR 1 - AIU)**

Dually Eligible Hospitals: If the hospital is eligible for Medicare and Medicaid incentive payments the attestation process differs from Medicaid Only hospitals. Hospitals are allowed to attest to AIU with Medicaid for the first payment year, but must attest to Meaningful Use with Medicare for the first payment year. Medicare sends IME your Meaningful Use data.

Medicaid Only Hospitals: If the hospital is only eligible for a Medicaid payment, all attestation data must be submitted via the IME EHR Incentive Payment Program portal. All Iowa hospitals should be registered as dually eligible for the incentive program and are expected to attest to MU through the CMS website. EHs will attest to other eligibility questions, such as those regarding patient volume, in the PIPP system for each program year.

Clicking on 'Apply for Incentive (Attest)' link displays the Provider Attestation screen.

The 'Provider EHR Criteria' section displays the attestation question pages that must be completed. Begin your application by selecting one of the 'Attest' links. You must respond to all of the questions on each page. Once you have answered the questions on a page, click "OK". If no errors are received your data is saved and you will be returned to the Provider Attestation main page to select another question page. If errors are displayed, you must correct any errors before your data is saved. You have the ability to change your answers on any page up until your application is submitted for review.

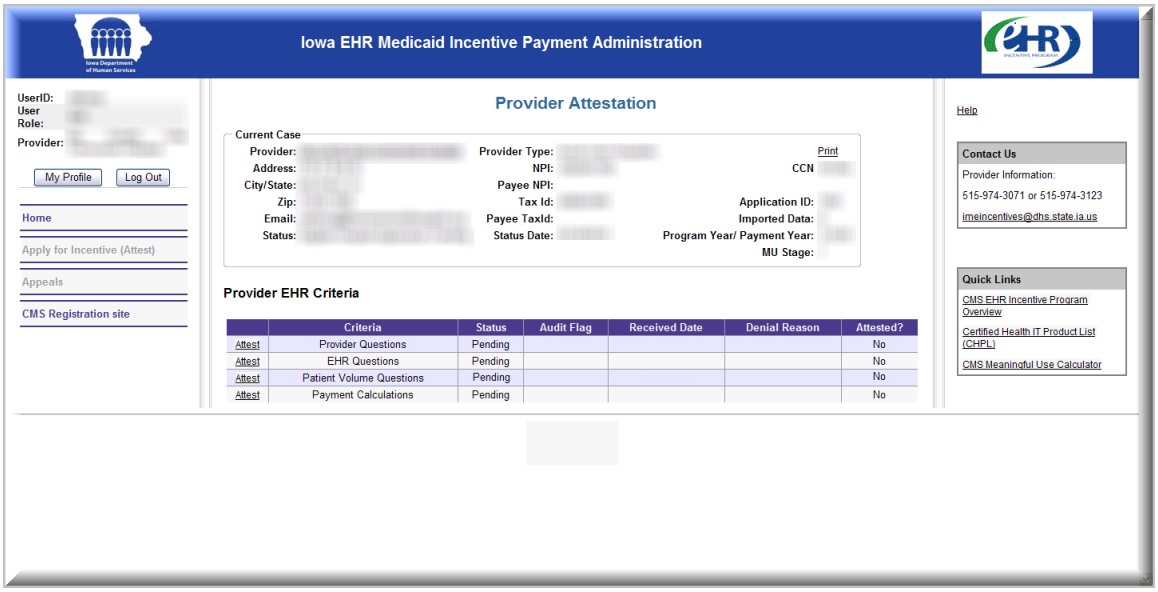


Figure 31 - EH Attestation Page

Each page must be completed successfully to submit an application for an incentive payment.

Criteria:

- Provider Questions – General questions used to determine incentive payment eligibility
- EHR Questions – Questions specific to the certified EHR system/module(s) you use
- Patient Volume – Questions specific to the Medicaid patient volume requirement of the program
- Payment Calculations – Calculator used to calculate the incentive payments

Status:

- Pending – Answers have not been confirmed or saved
- Attested – Answers have been confirmed or saved
- Pass – Question page has been approved in one or more of the IME review processes
- Fail – Question page has been denied in one or more of the IME review processes

Received Date – Date of the latest status change

Denial Reason – Return and denial reasons are displayed in this column

Attested? – "No" will change to "Yes" as you complete each page.

2.4.3.1 *Provider Questions*

- Type of hospital?
  - Critical Access Hospital (CAH)
  - Children's Hospital
  - Acute Care Hospital
- Does the hospital have any sanctions pending?
  - Yes - A text box is displayed for you to enter a brief description of the sanction(s). The description is limited to 100 characters. Please upload any necessary supporting documentation or comments.
  - No
- Is the hospital's average patient length of stay less than 25 days?
  - Yes
  - No – To be eligible for incentive payments a hospital's average length of stay must be 25 days or less. Please check your figures before continuing with the data input.
- Upload supporting documentation
  - Sanctions Details
  - Proof of Average Length of Patient Stay
  - Other

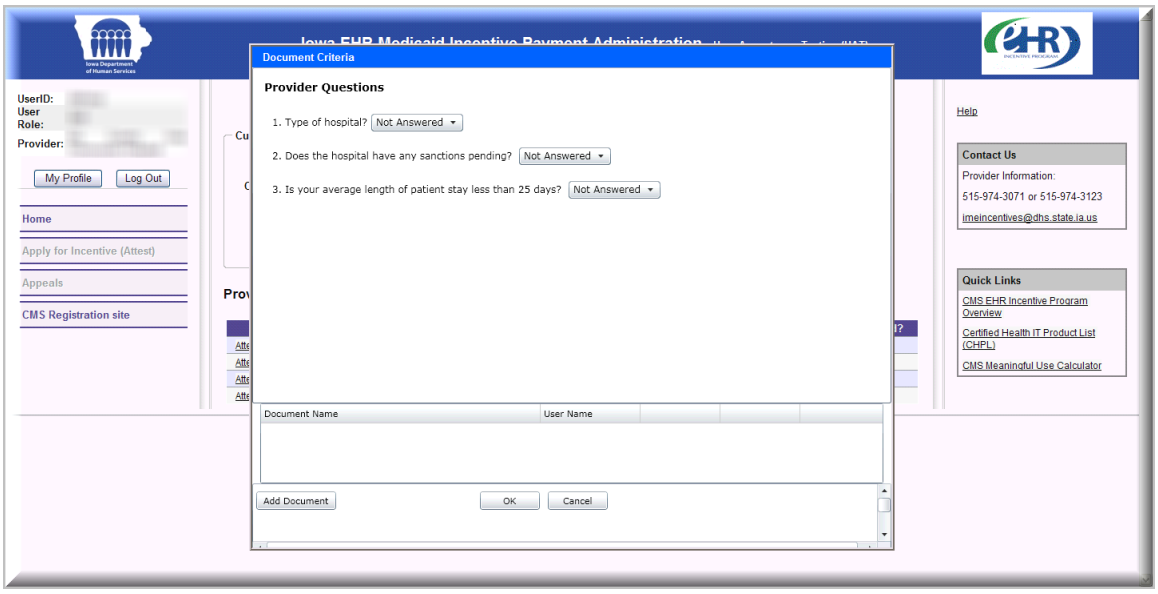


Figure 32 - EH Provider Questions

2.4.3.2 *EHR Questions*

- Has the hospital adopted, implemented or upgraded to certified electronic health record (EHR) technology?
  - Yes

  - No - In order to attest, the hospital must have adopted, implemented or upgraded to certified electronic health record technology
- The hospital's CMS EHR Certification number:
  - If you included your EHR Certification number in your CMS registration, this field is pre-populated with that number. Please verify this number is accurate and correct if needed.
  - If you did not include your EHR Certification number in your CMS registration you must enter this number here. A valid EHR Certification number is required on this page.
  - FOR MEANINGFUL USE YEARS:
    - The CMS EHR Certification number used in previous years will not be displayed; you must enter your EHR Certification number.
      - A valid EHR Certification number must be entered
      - If the EHR Certification number you enter does not match the EHR Certification number on record for previous years you will be required to upload supporting documentation for the new EHR technology
- Name, version, and description of Certified EHR System:
  - Enter the name, version and a brief description of your Certified EHR technology in the text box provided. The text box is limited to 100 characters. If more space is needed please attach a document with additional details.
- For what type of payment is the hospital applying?
  - AIU (Adopt, Implement, Upgrade)
  - MU (Meaningful Use)
- Have you attested with Medicare for a meaningful use payment?
  - Yes – Please provide the Payment Year for the Medicare incentive
  - No
- Upload supporting documentation
  - Invoice
  - Receipt
  - First Page and Signature Page of Contract
  - Other – Please specify

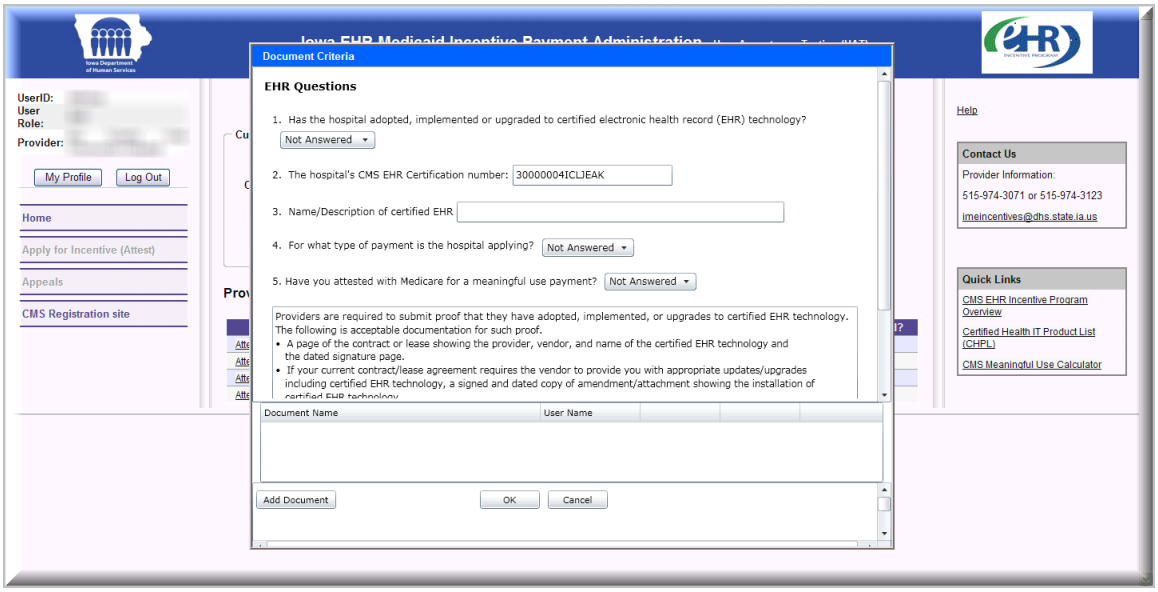
Documentation that proves you have Adopted, Implemented or Upgraded (AIU) your EHR system is required the first time you apply or you change your EHR technology in subsequent year applications. At least one supporting document must be uploaded.

Acceptable documentation for such proof:

- A page of the contract or lease showing the provider, vendor and name of the certified EHR technology and the dated signature page

- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment

A screenshot of CHPL showing a certified EHR system and/or modules is not sufficient documentation of proof of A/I/U.


Document Criteria
EHR Questions
1. Has the hospital adopted, implemented or upgraded to certified electronic health record (EHR) technology?
Not Answered
2. The hospital's CMS EHR Certification number: 30000004ICLJEAK
3. Name/Description of certified EHR
4. For what type of payment is the hospital applying? Not Answered
5. Have you attested with Medicare for a meaningful use payment? Not Answered
Providers are required to submit proof that they have adopted, implemented, or upgrades to certified EHR technology.
The following is acceptable documentation for such proof.
A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of
Document Name
User Name
Add Document
OK
Cancel
UserID:
User
Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator
Figure 33 - EH EHR Questions

2.4.3.3 *Patient Volume*

- Enter the Hospital Fiscal Year end date
  - The system will ignore the year selected
  - The MM/DD selected is used to ensure an appropriate 90-day period is used for the patient volume requirement
- Select the beginning date for the 90-day Patient Volume period in the previous Hospital Fiscal Year that ended during the previous Federal Fiscal Year.
  - The end date is auto-calculated
  - All eligible hospitals except Children's Hospitals must meet the Medicaid Patient Volume threshold of 10%
    - Children's Hospitals do not have a patient volume threshold requirement; therefore, they are not required to complete this section
  - Begin Date – mm/dd/yyyy
  - End Date – mm/dd/yyyy (auto-calculated)
- What is the total number of patient encounters within the selected 90-day qualifying period? (i.e. your denominator)

  - Enter the total patient encounter count for the selected 90-day qualifying period
  - For the purpose of calculating Patient Volume, the total patient encounters is the total population regardless of payment source where:
    - Services rendered to an individual per inpatient discharge; or
    - Services rendered to an individual in an emergency department on any one day

- What is the total number of paid Medicaid encounters for the selected 90-day qualifying period? (i.e. your numerator)
  - Enter the paid Medicaid encounter count for the 90-day qualifying period
  - For the purpose of calculating Patient Volume, a Medicaid encounter is defined as:
    - Services rendered to an individual per inpatient discharge where Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service; or
    - Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments and/or cost-sharing; and
    - Services rendered to an individual in an emergency department on any one day where Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service; or
    - Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments and/or cost-sharing
- Percentage of patient encounters over the selected 90-day qualifying period that were PAID by Medicaid:
  - This percentage is automatically calculated using the numerator and denominator information entered above
- Are any of the hospital's Medicaid patients covered by another state's Medicaid program?
  - Yes – A table is displayed to enter additional data. The state abbreviation and the encounter count for that state may be entered. If you have your Medicaid Provider ID for that state enter it in this table.
    - To ensure accurate multi-state reporting Iowa Medicaid encounters must also be reported in this table. IA is the default for your first entry.
  - No
- What is the auditable data source you are using to calculate patient volume?
  - EHR system
  - Billing system
  - Appointment Book
  - Other – provide a brief description of the 'other' source

- Upload supporting documentation
  - EHR system
  - Proof of Patient Volume
  - Other

NOTE: *To avoid a possible delay in the processing of your EHR incentive payment, please upload proof of your Patient Volume.* ***Do NOT include patient medical records as documentation.***

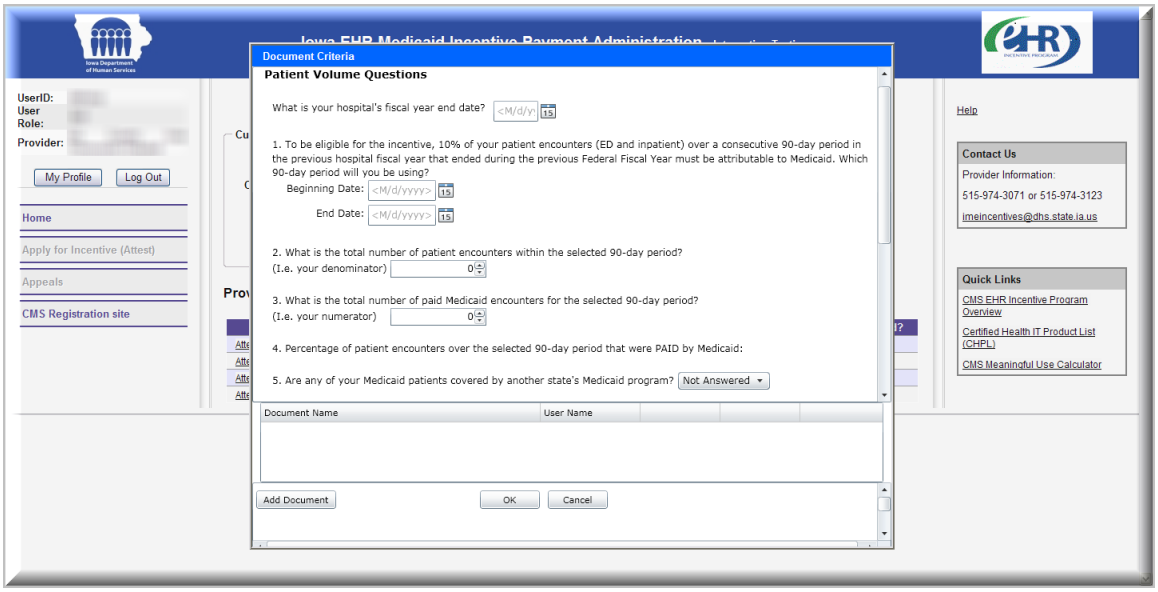

Document Criteria
Patient Volume Questions
What is your hospital's fiscal year end date?
1. To be eligible for the incentive, 10% of your patient encounters (ED and inpatient) over a consecutive 90-day period in the previous hospital fiscal year that ended during the previous Federal Fiscal Year must be attributable to Medicaid. Which 90-day period will you be using?
Beginning Date:
End Date:
2. What is the total number of patient encounters within the selected 90-day period?
(I.e. your denominator)
3. What is the total number of paid Medicaid encounters for the selected 90-day period?
(I.e. your numerator)
4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:
5. Are any of your Medicaid patients covered by another state's Medicaid program?
Not Answered
Document Name
User Name
Add Document
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 34 - EH Patient Volume

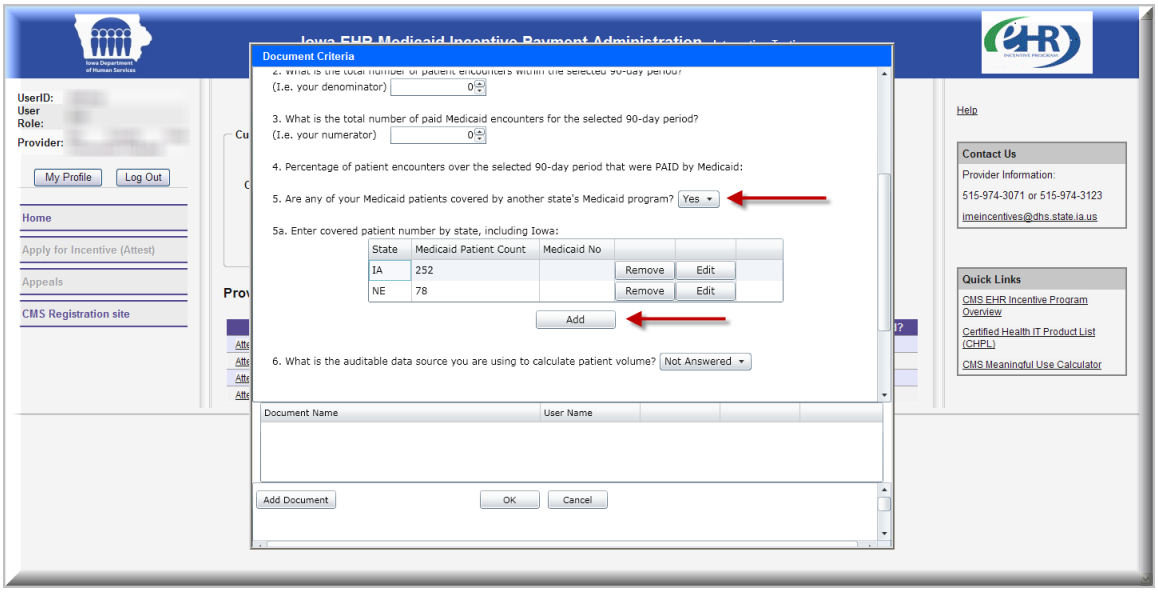


Figure 35 - EH Patient Volume 2 - Other State

2.4.3.4 *Payment Calculation*

Data entered in this screen is used to calculate the hospital incentive payment amounts.

Hospitals can use any auditable data source for calculating the incentive payment. References to the Medicare cost report are included in each section for guidance.

Critical access hospitals may use an independent auditors report for proof of charity care, minus bad debt

- Indicate the auditable data source you are using:
  - Other – supporting documentation is required
  - CMS Hospital Cost Report
  - Both – supporting documentation is required
- Overall EHR Amount
  - Current Year Discharges
  - Prior Year 1 (Discharges)
  - Prior Year 2 (Discharges)
  - Prior Year 3 (Discharges)
  - Click 'COMPUTE'
- Medicaid Computation
  - Total Medicaid Days – Number of inpatient-bed-days attributable to Medicaid and Medicaid Managed Care
  - Total Hospital Charges
  - Other Uncompensated Care Charges (aka Charity Charges)
  - Total Hospital Days
  - Click 'COMPUTE'
- Are you including patients also covered by Medicare Part A or Medicare Advantage in your total Medicaid days?
  - Yes
  - No
- Upload supporting documentation
  - Proof of hospital calculator data
    - Required if the auditable source selected above is 'Other' or 'Both'

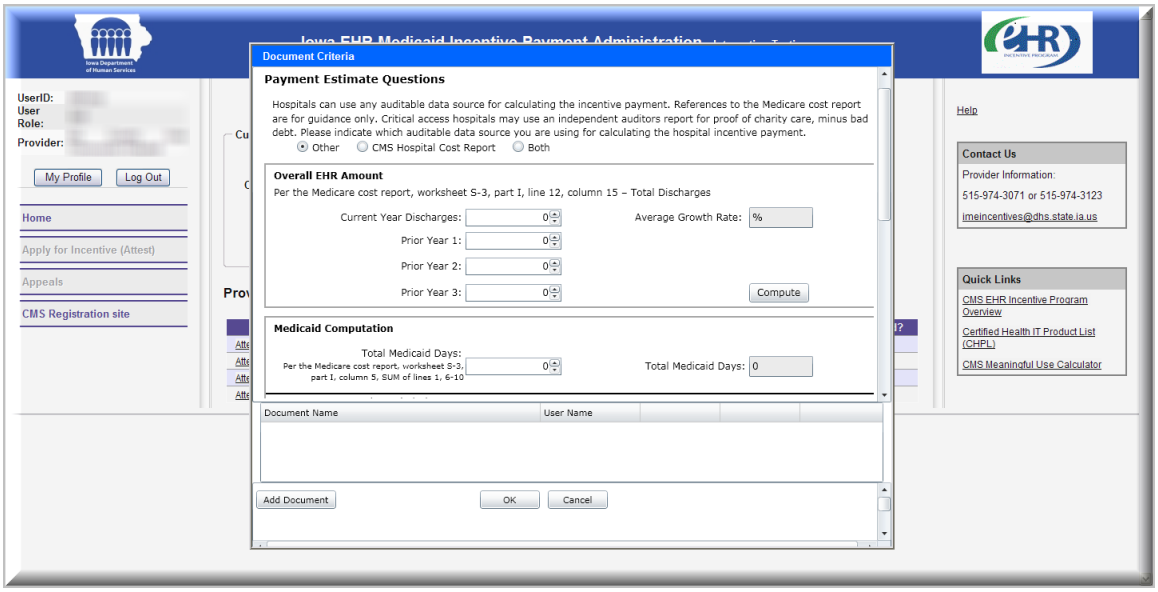

Document Criteria
Payment Estimate Questions
Hospitals can use any auditable data source for calculating the incentive payment. References to the Medicare cost report are for guidance only. Critical access hospitals may use an independent auditors report for proof of charity care, minus bad debt. Please indicate which auditable data source you are using for calculating the hospital incentive payment.
Other
CMS Hospital Cost Report
Both
Overall EHR Amount
Per the Medicare cost report, worksheet S-3, part I, line 12, column 15 – Total Discharges
Current Year Discharges:
Prior Year 1:
Prior Year 2:
Prior Year 3:
Average Growth Rate:
Compute
Medicaid Computation
Total Medicaid Days:
Per the Medicare cost report, worksheet S-3, part I, column 5, SUM of lines 1, 6-10
Total Medicaid Days:
Document Name
User Name
Add Document
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 36 - EH Payment Calculator

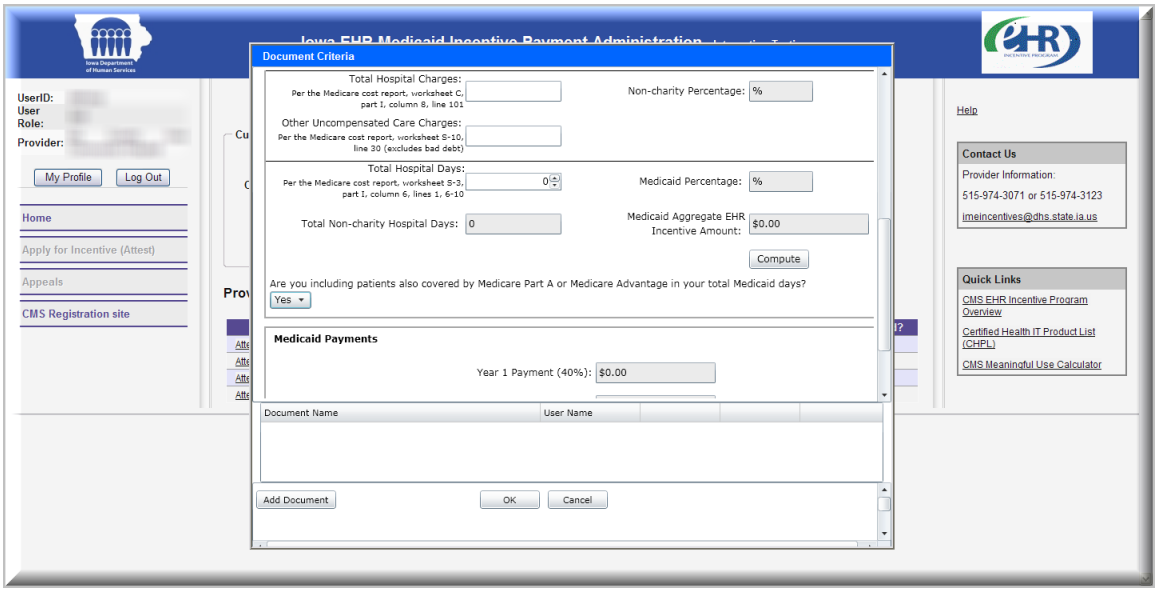


Figure 37 - EH Payment Calculator 2

2.4.4 **EH Provider Attestation Information (Meaningful Use Years)**

All IME hospitals have registered dually eligible therefore must attest to MU with Medicare. Medicare will forward the hospital's MU data to IME. Once the MU data is received an email notification will be sent prompting you to log in to the PIPP portal to attest to the Medicaid requirements. Complete the attestation pages covered in section 2.4.3. You must meet the Medicaid requirements every year to be qualified for Medicaid EHR incentive payments.

When you log in to the system to apply for your Medicaid EHR incentive payment, your MU screens is set to Pass or Fail depending on the data received from CMS.

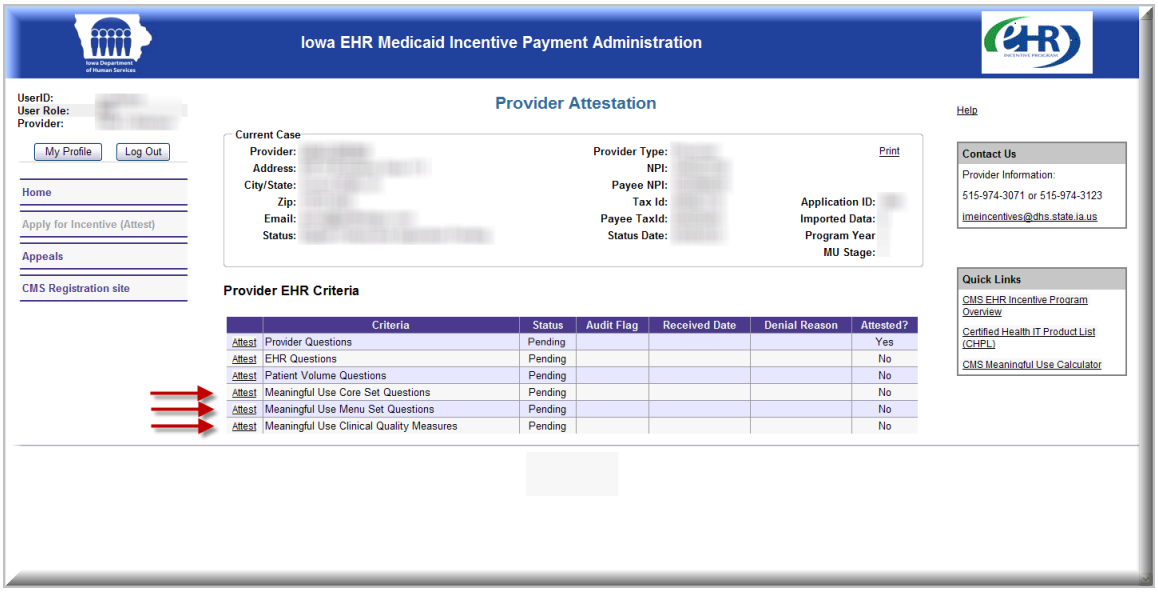


Figure 38 - Meaningful Use Attestation Pages

2.4.5 **Submit Attestation for Review**

Once all Attestation links have been completed, the 'Attested?' column on the far right will display 'Yes' for all rows.

When you complete all attestation pages, "Submit for Review" is displayed. After clicking that button, a page is displayed requiring you to agree or disagree with the statements listed in the box. Please read the text thoroughly and select the appropriate statement. If you click "Do Not Agree," your attestation will not be submitted. Clicking on "Agree" submits your information to IME for review.

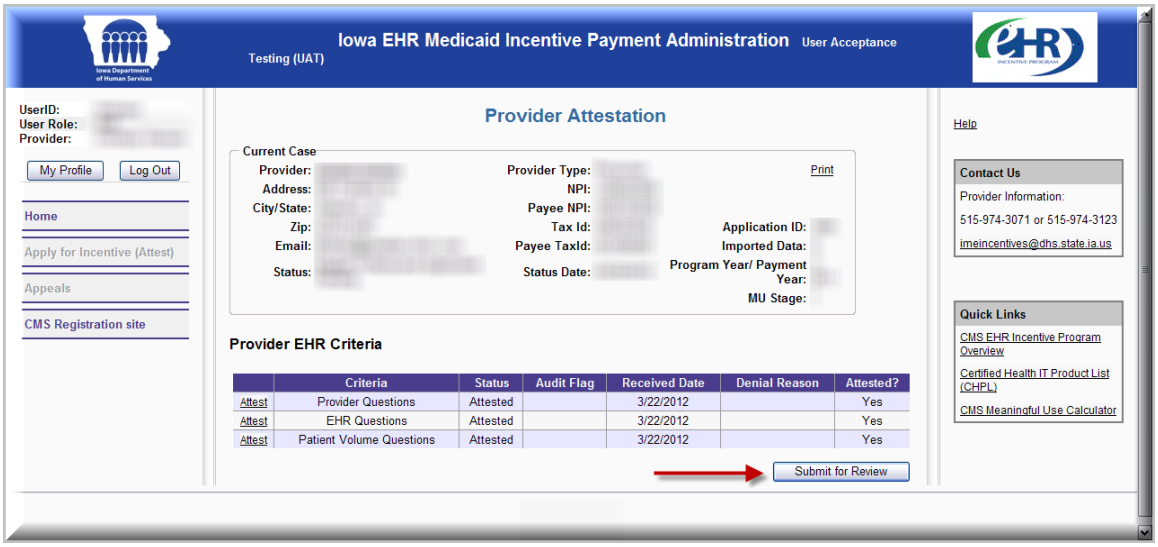


Figure 39 - Submit for Review

If you are not currently enrolled as an Iowa Medicaid provider an additional page is displayed requiring you to either agree or disagree with the statements listed. Please read the text thoroughly and select the appropriate statement. If you click "Do Not Agree," your attestation will not be submitted. Clicking on "Agree" submits your information to IME for review.

Another pop-up box will appear indicating that your information has been successfully submitted. Click on "Log Out" (upper left hand side) and you are done!

If at any time you want to see the status of your attestation, return to the portal, log in, and the latest information will be available to you. You also have the ability to print your application questions and answers on the Provider Attestation page.

Following submission, the first column will disappear (Attest link) preventing any changes to your application. If IME discovers a problem or requires additional information, your application will be returned for you to make changes.

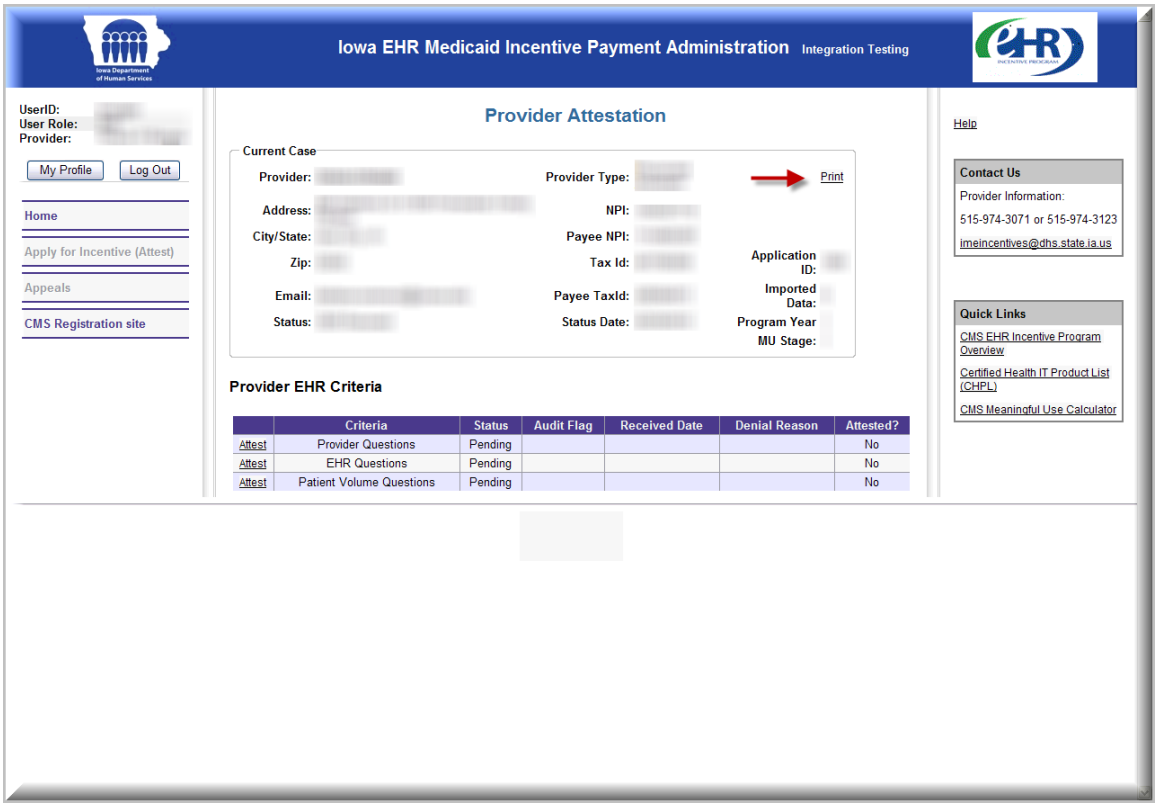


Figure 40 - Print Application

2.5 *Appeals (EP and EH)*

If your EHR incentive payment application is denied or you do not agree with the payment amount you have the right to dispute the decisions by filing an appeal. An appeal must be submitted within 30 calendar days of the decision date.

2.5.1 **Access Appeals Page**

Appeals for the EHR Incentive Payment Program follows the existing IME appeal process. Please refer to https://dhssecure.dhs.state.ia.us/forms/ for Iowa DHS appeal instructions.

A link to the electronic appeal form is provided for your convenience on the home page of the PIPP portal.

Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Dashboard
Correspondence:
Payment History:
Current Status: Eligible Professional Application Denied
On this page, you will find a list of the correspondence sent to you by IME. In addition, you will be provided the status of your attestation.
This system contains questions on multiple screens. The answers from each screen are stored at the time the individual screen is saved. Please be prepared to complete all questions upon entering an individual screen. The system will save the data only when an entire question screen has been completed successfully (including document upload requirements) with no errors. If you leave an individual screen prior to completing or resolving any errors, your data will not be saved for that individual screen. However, you may complete screens at different times and your answers will be saved for you to complete the remaining screens at a later time. Please refer to the Provider User Manual in the User Manual link for additional information.
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 41 - Appeals link

2.6 *Recover / Reset Log In Credentials (EP and EH)*

In the event you need to recover your User Name or reset your Password, please follow these steps:

2.6.1 **Recover User ID**

- Click on 'Recover User ID' link from the Log In page.
- Enter the following information:
    - CMS Registration Number (NLR#)
    - NPI

- Tax ID
- An email with your User Name will be sent to the email address on file in the CMS R&A system.

Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
Provider Web Registration
Incentive Program Information
Register with CMS
FAQ
Welcome
Please Log In
User Name:
Password:
Recover User ID
Reset Password
Log In
WARNING!
This system is for use by authorized personnel only. Individuals accessing this system without authority or in excess of their authority are in violation of Federal and/or State laws, regulations and policies and may be subject to criminal, civil and/or administrative actions.
Any information, including personal information, on this computer system may be intercepted, recorded, read, copied and disclosed by and to authorized personnel for administrative purposes, including criminal investigations.
Anyone using this system expressly consents to such monitoring and SHOULD HAVE NO EXPECTATION OF PRIVACY for any information stored or communicated in or through this system.
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator
Figure 42 - Recover User ID link

Figure 43 - Recover User ID

Figure 44 - Recover User ID Email

2.6.2 **Reset Password**

- Click on 'Reset Password' link from the Log In page.
- Enter the following information:
  - User Name
  - Click Next
- Select appropriate security question
  - You must provide a correct response to one of the three questions you answered when creating your User Name
  - Click Next
- You will be taken to a screen to create a new password
- Enter the new password
- Confirm the new password
  - The new password must be different from your previous passwords
  - Also note you will need to use the same guidelines you used when creating your initial password:
    - Between 7 and 10 characters
    - Must contain at least one non-alphanumeric character (symbol)
    - Must contain at least one upper case character
    - Must contain at least one lower case character
- Click 'Save'
- You are now able to log in to the system using your newly created password.

Iowa EHR Medicaid Incentive Payment Administration
Integration Testing
Provider Web Registration
Incentive Program Information
Register with CMS
FAQ
Welcome
Please Log In
User Name:
Password:
Recover User ID
Reset Password
Log In
WARNING!
This system is for use by authorized personnel only. Individuals accessing this system without authority or in excess of their authority are in violation of Federal and/or State laws, regulations and policies and may be subject to criminal, civil and/or administrative actions.
Any information, including personal information, on this computer system may be intercepted, recorded, read, copied and disclosed by and to authorized personnel for administrative purposes, including criminal investigations.
Anyone using this system expressly consents to such monitoring and SHOULD HAVE NO EXPECTATION OF PRIVACY for any information stored or communicated in or through this system.
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator

Figure 45 - Reset Password Link

Figure 46 - Reset Password

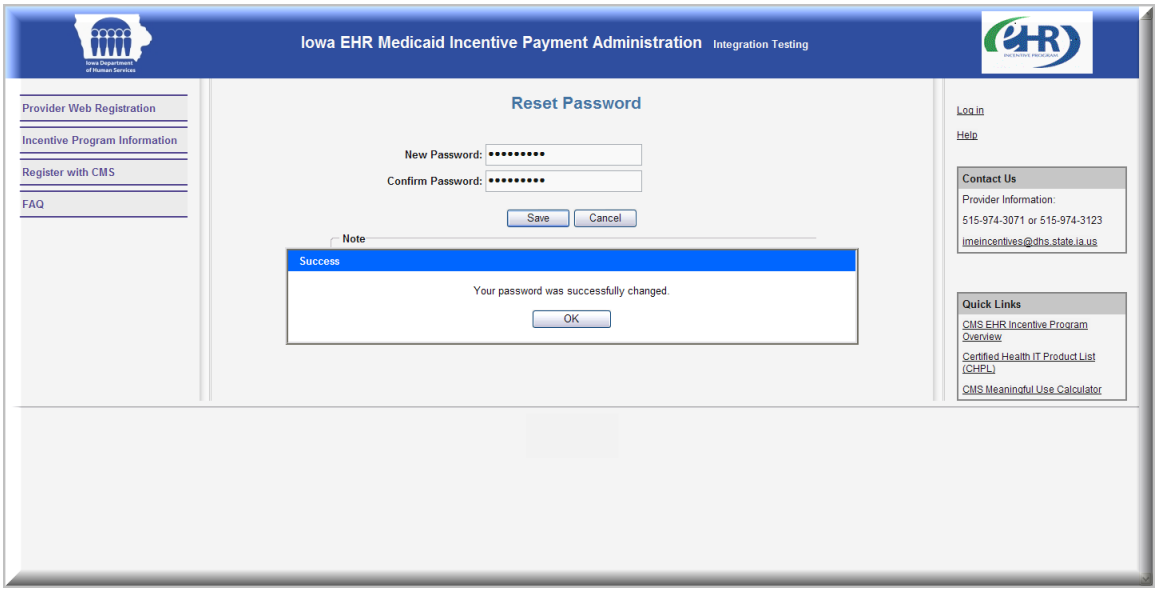


Figure 47 - Create New Password

2.6.3 **Change Password**

Follow the steps below to change your password.

- Log in
- Click on 'My Profile' on the left of the Dashboard
- Enter your old password
- Enter and Confirm your new password
- Answer security question
- Click 'Save'

Figure 48 - My Profile - Change Password

Figure 49 - My Profile

2.7 *Upload Supporting / Required Documentation (EP and EH)*

All Attestation screens in the IME PIPP portal allow for the upload of supporting documentation. Some screens require supporting documentation be uploaded. Please follow the steps below to upload your documentation wherever applicable. ***Do NOT include patient medical records as documentation. For proof of EHR documentation, do NOT send a copy of the entire contract or lease.***

NOTE: For security purposes the uploaded documents are limited to the following file types:

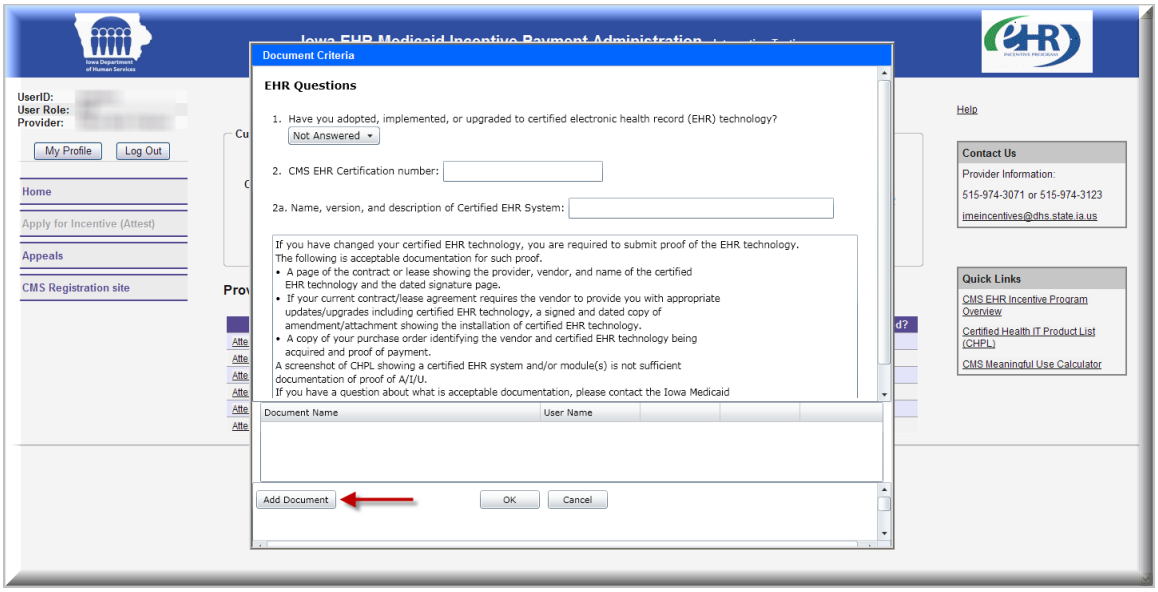
- Excel - .xls, .xlsx
- Word - .doc, .docx, .rft
- Power Point - .ppt
- Text - .txt
- PDF - .pdf
- Images - .jpg, .jpeg, .gif, .png, .bmp, .tiff

2.7.1 Add Document

1. Click 'Add Document
2. Click on 'Document Name' drop down box to select your document type
    - This drop down box will vary depending on the Attestation screen to which you are uploading.
3. Click 'Upload Document'
    - Select file to be uploaded

4. Once file is done uploading and the selected file name appears in the 'Document File Name' field – Click 'OK'
5. You will be returned to the main screen of the selected Attestation. To upload another document, please repeat steps 1 through 4.

NOTE: *The current file size limit is 10MB.* ***Do NOT include patient medical records as documentation. For proof of EHR documentation, do NOT send a copy of the entire contract or lease.***


Document Criteria
EHR Questions
1. Have you adopted, implemented, or upgraded to certified electronic health record (EHR) technology?
Not Answered
2. CMS EHR Certification number:
2a. Name, version, and description of Certified EHR System:
If you have changed your certified EHR technology, you are required to submit proof of the EHR technology.
The following is acceptable documentation for such proof.
• A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
• If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
• A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.
A screenshot of CHPL showing a certified EHR system and/or module(s) is not sufficient documentation of proof of A/I/U.
If you have a question about what is acceptable documentation, please contact the Iowa Medicaid
Document Name
User Name
Add Document
OK
Cancel
UserID:
User Role:
Provider:
My Profile
Log Out
Home
Apply for Incentive (Attest)
Appeals
CMS Registration site
Help
Contact Us
Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us
Quick Links
CMS EHR Incentive Program Overview
Certified Health IT Product List (CHPL)
CMS Meaningful Use Calculator
Figure 50 - Add Document

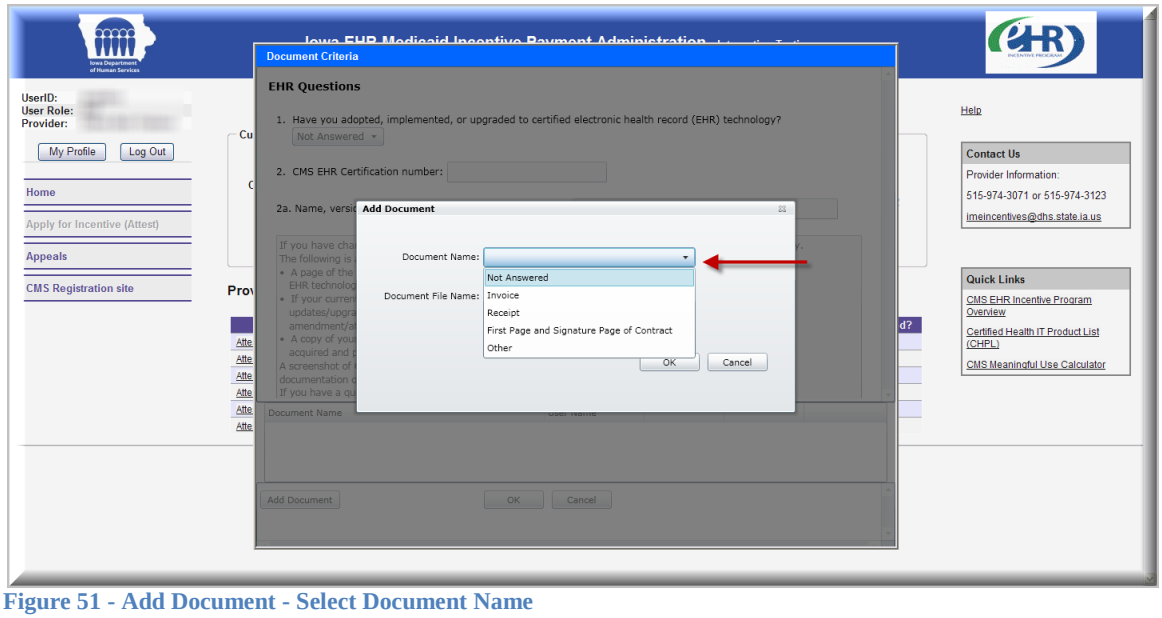


Figure 51 - Add Document - Select Document Name

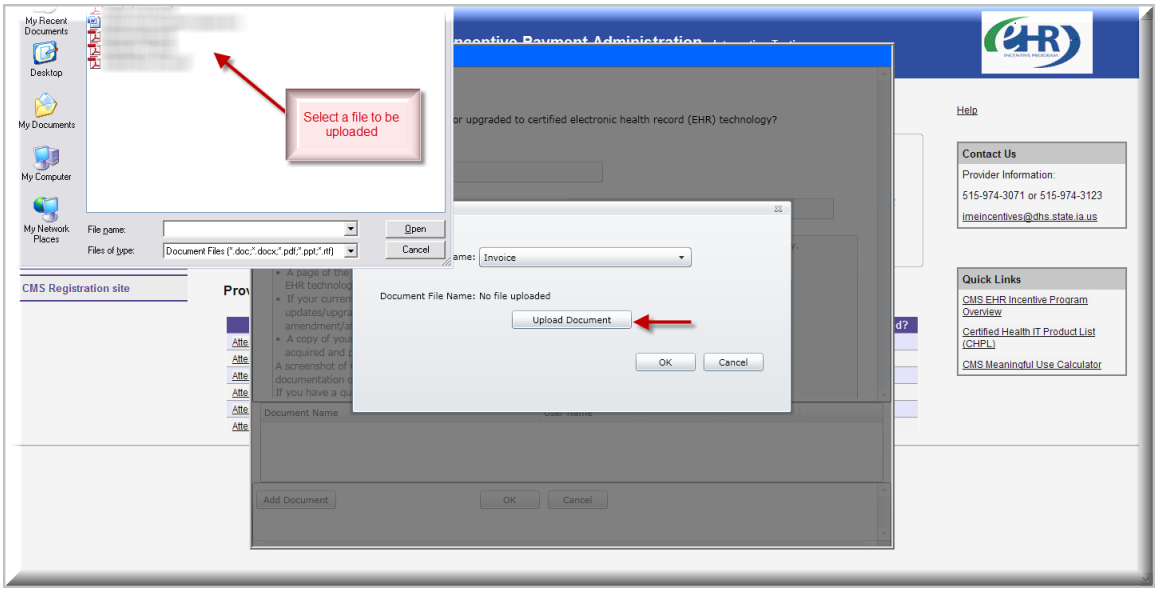


Figure 52 - Add Document - Select File

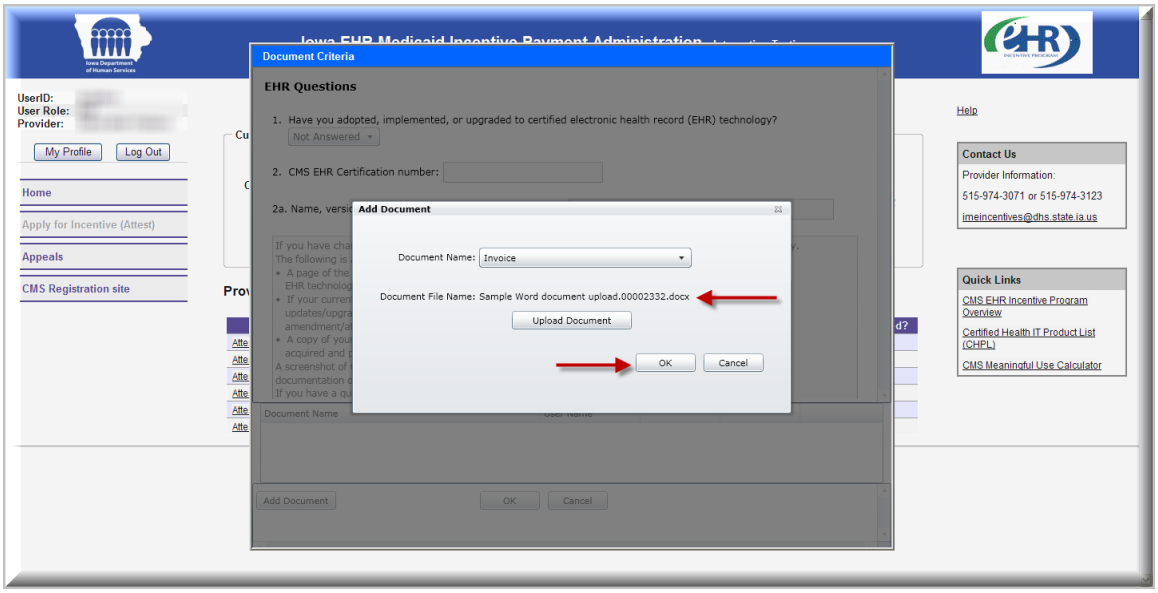


Figure 53 - Add Document - Confirm